AGREEMENT

between

COUNTY OF MACOMB

and

POLICE OFFICERS ASSOCIATION OF MICHIGAN

representing the

MEDICAL EXAMINER EMPLOYEES

January 1, 2023
to
December 31, 2025

TABLE OF CONTENTS

AGREEMENT

This Agreement entered into on the first day of January, 2023, between the County of Macomb, hereinafter collectively referred to as the Employer, and the Police Officer Association of Michigan (POAM), hereinafter referred to as the Union, on behalf of employees set forth in Article 19, Recognition.

PURPOSE AND INTENT

The general purpose of this Agreement is to set forth terms and conditions of employment, and to promote orderly and peaceful labor relations for the mutual interests of the Employer, its employees and the Union.

The Parties recognize that the best interests of the community and the job security of the employees depend upon the Employer's success in establishing a proper service to the community.

To these ends, the Employer and the Union encourage to the fullest degree friendly and cooperative relations between the respective representatives at all levels and among all employees.

NON-DISCRIMINATION

The provisions of the Agreement shall apply to all employees regardless of religion, race, color, national origin, age, height, weight, familial status, marital status, sex, sexual orientation, gender identity or union affiliation.

ARTICLE 1

BEREAVEMENT LEAVE

Upon presentation of proper proof as required by the Employer, such as, but not limited to, newspaper death or obituary notices, the following shall apply:

A. A full-time employee may elect to take up to three (3) days off with pay due to a death in the employee's family as follows: parent, current step parent, current mother-in-law, current father-in-law, current spouse, children, current daughter-in-law, current son-in-law, current step children, brother, sister, grandparent or grandchildren. It shall also include any person who is normally a member of the employee's household.

B. The employee may elect to take up to three (3) bereavement leave days chargeable to Sick Leave or Paid Time Off due to the death of an Employee's friend or family member, other than those listed in section A. of this article.

C. Full-time employees are permitted to take up to four (4) hours of bereavement leave with pay to attend the funeral of an employee who worked within the same department, provided attendance is during the employee's normally scheduled work hours and does not interfere with the operational needs of the Department/County.

Bereavement Leave requests made pursuant to sections B. and C. of this article are subject to prior approval by the Employer and shall not be unreasonably withheld or denied.

ARTICLE 2

COURT TIME

With department approval, Medical Examiner Investigators who are subpoenaed to appear in court during off duty hours, will be paid a minimum of two (2) hours of straight time or overtime, if eligible.

ARTICLE 3

DISCIPLINE AND DISCHARGE

A. Discipline:

1. Should circumstances warrant, an employee may be disciplined for just cause. Disciplinary actions or measures may include, but are not limited to, the following: oral reprimand, written reprimand, suspension or discharge.

2. Employees in the bargaining unit shall be entitled to their right to representation at an interview or meeting that the employee reasonably believes could result in disciplinary action or discharge.

3. Any disciplinary action or measures imposed upon an employee may be processed as a grievance through the regular grievance procedure or through the special conference provisions as provided for in this Agreement.

4. If the Employer has reason to reprimand an employee, it shall be done in a manner that will not embarrass the employee before other employees or the public.

B. Suspension And Discharge:

1. If the Employer feels there is just cause for suspension or discharge, the employee and his/her steward will be notified in writing that the employee has been so disciplined. Such notification shall contain the charge(s) against the employee.

2. The Union shall have the sole right to take a suspension and/or discharge as a grievance at the 3rd Step of the Grievance Procedure, and the matter shall be handled in accordance with this procedure.

C. Records in Personnel Files:

1. Where disciplinary action has been put in writing, a copy shall become part of the employee's personnel file.

2. Any record of disciplinary action shall remain in the employee's personnel file. If after two (2) years from the date of discipline there have been no further incidents of a similar nature, the employee may request in writing for the Employer to remove the discipline from the personnel file. If the employee has not violated paragraph 3 below, the employer will remove such discipline from the employee's personnel file. When such request has been granted, the discipline shall be kept by the Employer in a separate file and shall be maintained for record keeping purposes only and will not be used in progressive discipline.

3. If, prior to the end of the above two (2) years, the employee is disciplined for a similar incident, the record of the first disciplinary action shall be maintained in the employee's file for an additional two (2) years, or a total of four (4) years. Record(s) of any similar incident(s) which causes subsequent disciplinary action to be imposed shall remain in the employee's personnel file until the previous similar discipline is authorized to be removed pursuant to paragraph 2, above.

4. If a record of discipline is not subject to paragraph 3 above and is older than two (2) years, it will not be relied upon for the purposes of progressive discipline.

5. It is the responsibility of the Employee or the Association to petition the Employer for removal of discipline records. Employees are encouraged to exercise their right to review their personnel files in accordance with the provisions of this collective bargaining agreement and/or human resources policies.

ARTICLE 4

EMERGENCY MANAGER

The Parties agree that this Collective Bargaining Agreement is applicable to an emergency manager as defined in Public Act 4 of 2011. The Union's agreement to this provision was not by negotiation, rather, this provision is required by Public Act 9 and accordingly is a prohibited subject of bargaining.

ARTICLE 5

EMPLOYEE DEFINED

A. Regular Full-Time Employee: A "Regular Full-Time Employee" is an individual employed in a full-time budgeted position and regularly scheduled to work thirty (30) hours or more per week for six (6) consecutive months. Regular full-time employees are entitled to benefits as specifically outlined in this Labor Agreement.

B. Regular Part-Time Employee: A "Regular Part-Time Employee" is an individual employed in a part-time budgeted position and regularly scheduled to work less than thirty (30) hours per week for six (6) consecutive months. Regular part-time employees shall not be entitled to any benefits pursuant to this Labor Agreement.

ARTICLE 6

FLEXIBLE SPENDING ACCOUNT

The Employer shall offer a pre-tax Flexible Spending Account, as authorized by Section 125 of the Internal Revenue Service Code. The Reimbursement Account Program shall be limited to the Health Care and Dependent Care provisions of the IRS Code. Employees shall have the option of participating in the Health Care and/or Dependent Care program. The Employer supports the establishment of a Premium Only Plan (POP) based upon the limitations of the Internal Revenue Service code and the vendor administering the program.

ARTICLE 7

GRIEVANCE PROCEDURE

The Parties intend that the grievance procedure as set forth herein shall serve as a means for a peaceful settlement of all disputes, including but not limited to dismissals, suspensions, demotions and other disciplinary actions of any type that may arise between them concerning the interpretation or operation of this Agreement without any interruption or disturbance of the normal operation of the Employer's affairs. Any employee having a grievance in connection with his/her employment MUST present it to the Employer within fifteen (15) days after the occurrence of the alleged event causing the grievance in the following manner:

Step 1:

The employee must first discuss the specific grievance with their immediate Supervisor. A Steward or Union President shall be present at this meeting; otherwise, the complaint shall not be considered a formal grievance, as outlined in this Article. The immediate Supervisor or designee shall attempt to adjust the matter consistent with the terms of this Agreement as soon as possible, and shall, within five (5) days give a verbal answer to the employee.

Step 2:

If the grievance is not settled at the verbal step, a written grievance may be filed by the Steward or Union President with the employee's Department Head within ten (10) days after the immediate Supervisor's response at Step 1. When a grievance is reduced to writing, it shall contain the name, position and department of the grievant, a clear and concise statement of the grievance, the relief sought, the date the incident or violation took place, the specific section(s) of the Agreement, if any, alleged to have been violated, the signature of the Steward or Union President and the date the grievance is reduced to writing. Inadvertent omission of minor information will not prejudice the processing of the grievance.

A meeting shall be held between the Parties within ten (10) days, unless mutually waived in writing. Within five (5) days after the completion of the meeting, or the waiver thereof, the Department Head shall give a written answer to the Steward or Union President.

Step 3:

If the grievance is not settled at Step 2, such grievance may be submitted by the Steward or Union President to the Director, Human Resources and Labor Relations or their designee, with a courtesy copy to the Department Head, within ten (10) days after the Department Head's written response has been received by the Union President or Steward. A grievance number shall be assigned when the grievance is submitted to the Human Resources and Labor Relations Department.

The Union President or designee must make a request in writing to conduct a Step 3 grievance meeting. A Grievance Committee, composed of the Union President, the Steward, the Director, Human Resources and Labor Relations or their designee and the Department Head or their designee shall conduct a Step 3 meeting within fifteen (15) days of the receipt of the Union President's written request. An officer of POAM may be present at the Step 3 meeting. In addition, a witness(es) may be in attendance if deemed necessary by both Parties.

The decision of the Director, Human Resources and Labor Relations or designee shall be given in writing to the Union President within ten (10) days of the completion of the Step 3 meeting.

GRIEVANCE MEDIATION: If the grievance is not resolved at Step 3 of the grievance procedure, either party may pursue the matter to Mediation by filing a request with the Michigan Employment Relations Commission (MERC) and notifying the other party concurrently within five (5) days of the grievance meeting. If the mediation process is unsuccessful, either party shall have the right to move the matter to arbitration.

Step 4:

If the grievance is not resolved at Step 3, or through grievance mediation, the Union President or designee has thirty (30) days from the Step 3 answer or the date of the decision issued by the mediator in the event of grievance mediation, to file a Notice of Intent to Arbitrate, by sending a letter to the Director, Human Resources and Labor Relations. If the Union President or designee fail to request arbitration within this time limit, the grievance shall be deemed not eligible to go to arbitration.

A. The Notice of Intent to Arbitrate shall identify the name of the Arbitrator selected by the procedure set forth below.

B. All arbitration hearings shall be governed by the rules of the American Arbitration Association ("AAA"), to the extent that those rules are not inconsistent with this Agreement.

C. Any arbitrator selected shall have only the functions and authority set forth herein. The scope and extent of the jurisdiction of the arbitrator shall be limited to those grievances arising out of and pertaining to the respective rights of the Parties within the terms of this Agreement. The arbitrator shall be without power or authority to make any decision contrary to or inconsistent with in any way, the terms of this Agreement or of applicable laws or rules or regulations having the force and effect of law. The arbitrator shall be without power to modify or vary in any way the terms of this Agreement.

D. The arbitrator shall have no power to establish or modify job classifications, to establish wage rates, or to change any existing wage rate, work schedule, or assignment, except for grievances arising out of Article 32, Wage Rates For New Classifications.

E. In the event a grievance is submitted to an arbitrator and the arbitrator finds that he/she has no jurisdiction to rule on such grievance, it shall be referred back to the Parties without an answer or recommendation on the merits of the grievance.

F. To the extent that the laws of the State of Michigan permit, it is agreed that any arbitrator's decision shall be final and binding on the Union and its members, the employee or employees involved, and the Employer, and that there shall be no appeal from any such decision unless such decision shall extend beyond the limits of the powers and jurisdiction herein conferred upon such arbitrator.

G. In matters concerning discipline imposed, the arbitrator shall have the authority to sustain, overrule or mitigate the disciplinary action.

H. The decision of the arbitrator shall be in writing and due within thirty (30) days of the close of the hearing. This time limit may be waived by mutual written consent of the Parties.

I. The fees and approved expenses of an arbitrator will be paid by the losing party. The arbitrator in their award shall designate the losing party. In cases where there is no clear loser, the arbitrator shall so designate and the fees and expenses of the arbitrator shall be paid by the parties equally.

GENERAL CONDITIONS:

A. Selection of the Arbitrator:

1. Within thirty (30) days of the written notice of intent to arbitrate, the County and the Association shall attempt to mutually select an Arbitrator. In the event that the parties cannot agree upon an Arbitrator to hear the unresolved grievance within that thirty (30) days, the Union will have an additional (10) days to request the Michigan Employment Relations Commission (MERC) to provide a list of impartial arbitrators in accordance with its applicable rules and regulations. Any grievance scheduled in accordance with this procedure is considered settled and not subject to further review.

2. The party seeking arbitration shall notify the arbitrator within 10 days of their selection and begin to arrange the scheduling of the arbitration hearing.

3. Upon written agreement of the Parties, an arbitrator may hear more than one case.

B. Withdrawal Of Grievances: A grievance may be withdrawn. A withdrawn grievance may be reinstated within twenty (20) days from the date of withdrawal. If a grievance is not reinstated within twenty (20) days of the date of withdrawal it cannot be reinstated.

C. Computation Of Back Wages: All claims for back wages shall be limited to the amount of straight time wages less any unemployment compensation, and/or wages earned from any other sources during the period in question.

D. Time Of Appeals: Any grievance not appealed within the time specified in the particular step of the Grievance Procedure, shall be considered settled and not subject to further review. In the event that the Employer shall fail to supply the Union with its answer to the particular step within the specified time limits, the Union may appeal the grievance to the next step with the time limit for exercising said appeal, commencing with the expiration date of the Employer's period for answer.

E. Legal Rights: Nothing contained herein shall be deemed to abrogate or limit the rights guaranteed by existing statutes or court decisions.

F. Time Limits: Time limits may be extended or shortened by mutual written consent of the Parties.

G. Days Defined: All references to days as they pertain to the Grievance Procedure shall mean "working days". They do not include Saturdays, Sundays and designated holidays.

H. Access to Records: Records, reports and other information pertaining to a grievance which are requested by the Union shall be made available for inspection and copying by the Union, provided the proper representative of the Union makes a request for the specific document referenced above and, if applicable, the affected employee has authorized, in writing, the release of said information.

ARTICLE 8

HOLIDAY BENEFITS

A. Employees shall be entitled to holiday pay for the following designated holidays:

January 1st (New Year's Day)	Martin Luther King, Jr. Day
Presidents Day	One-half (1/2) day Good Friday
Memorial Day (observed)	Independence Day
Labor Day (observed)	Columbus Day
November 11th (Veterans' Day)	Thanksgiving Day
The day AFTER Thanksgiving	December 24th (Christmas Eve)
December 25th (Christmas Day)	December 31st (New Year's Eve)
June 19th (Juneteenth)	General Election Day in the EVEN numbered years

B. Holiday Benefits

1. Full-time employees, who qualify, who do not actually work on a scheduled Holiday shall be compensated straight time pay. Payments shall be included in the first regular payroll check of December.

2. All full-time employees who actually work on an identified Holiday will be paid, in addition to the Holiday Pay described in B.1. above, at a rate of time and one-half (1 ½) for hours actually worked on the scheduled date of the Holiday, in the pay period the Holiday is actually worked.

3. An employee shall receive holiday pay provided that he/she works the scheduled day before and the scheduled day after the holiday and the holiday, if scheduled, or is excused with pay for the entire day from work. Failure to receive pay and approval by not calling in or properly notifying the Employer regarding an absence on the scheduled day before and/or the scheduled day after a holiday and/or the holiday, if scheduled, shall result in the denial of holiday pay. Excuse shall be by medical certificate and/or Department Head approval. In order for an employee to avoid loss of pay, said employee, shall provide a medical certificate within three (3) working days. This provision shall not apply to employees on an approved leave of absence.

ARTICLE 9

INSURANCE BENEFITS

A. Life Insurance:

1. Full-time Employees (including DROP Participants):

   a. The life insurance benefit provided by the Employer shall be $50,000.

      The Employer will provide a payroll deduction option for employees wishing to purchase additional $25,000 increments of life insurance to a maximum of $325,000. Rates and conditions shall be those established by the insurance carrier.

      Based on the above language, an employee exercising their ability to purchase the maximum life insurance benefit of $325,000 would then have a total life insurance benefit of $375,000.

2. Retirees: The Employer will provide a life insurance benefit, in the amount of two thousand dollars ($2,000), to employees covered by this Agreement who retire and are eligible for and receive a

retirement allowance under the Macomb County Employees' Retirement Ordinance. Employees hired on or after January 1, 2016 will not be eligible for this life insurance benefit.

B. Insurance Benefits:

1. Only full-time employees (including DROP participants) and their eligible dependents will be eligible for Macomb County's Insurance Benefits which includes medical, prescription drug, dental and vision plans, effective their first day of employment with Macomb County.

2. Dependent Eligibility:

Full-time employees (including DROP participants) may elect to cover their current spouse on Macomb County's medical, prescription drug, dental and vision plans.

Full-time employees (including DROP participants) may elect to cover their eligible children up to the age of 26 on Macomb County's medical, prescription drug, dental and vision plans. Supporting documentation must be provided to the Human Resources and Labor Relations Department as necessary.

C. The Employer shall provide two medical plan options: a Preferred Provider Organization (PPO) and an Health Maintenance Organization (HMO) to all regular eligible full-time employees and their eligible dependents including prescription drug coverage, as outlined in Appendix B, Active Employee Benefits or its substantial equivalence. Full-time employees shall be required to comply with PA 152. Prior to the implementation of any deductions, the Employer will meet and confer on design, plan, or carrier changes to comply with PA 152.

1. Full-time employees who have a current spouse who is also employed full-time by Macomb County will be entitled to only one (1) medical, prescription drug, dental and vision plan for both employee and all eligible dependents. Such employee shall not be eligible for the insurance waiver.

2. Full-time employees who elect not to participate in Macomb County's medical and prescription drug plans and who has coverage elsewhere shall receive a monthly insurance waiver payment of $167.00. The insurance waiver will be paid in the employee's regular paycheck.

a. Full-time employees shall establish proof of their eligibility to receive the insurance waiver.

b. Full-time employees participating in the insurance waiver who lose coverage shall be allowed to enroll in Macomb County's medical, prescription drug, dental and vision plans as soon as administratively possible and the insurance waiver payments shall cease as soon as administratively possible.

D. 1. Retirees: Full-time employees hired before January 1, 2006, the Employer will provide a fully paid medical and prescription drug plan to the employee and the employee's eligible spouse, as defined in D.1.a. after eight (8) years of actual service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.

Full-time employees hired on or after January 1, 2006, the Employer will provide a fully paid medical and prescription drug plan to the employee and the employee's eligible spouse, as defined in D.1.a. after fifteen (15) years of actual service with the Employer, for the employee who leaves employment because of retirement and is eligible for and receives benefits under the Macomb County Employees' Retirement Ordinance.

a. Coverage shall be limited to the spouse of the retiree, at the time of retirement or DROP.

b. Coverage for the eligible spouse will terminate upon the death of the retiree unless the retiree elects to exercise a retirement option whereby the eligible spouse receives applicable retirement benefits following the death of the retiree.

2. Full-time employees hired on or after January 1, 2012 will not be eligible for Macomb County's medical, prescription drug, dental and vision plans for the employee's spouse in retirement.

3. All employees who retire or DROP after November 1, 2013, will have the medical and prescription drug plan as outlined in Appendix C, Post November 1, 2013 Retirees, until they are Medicare eligible, subject to the limitations and provisions of D.2. and D.4. of this Article. This provision does not apply to employees who retire or DROP prior to November 1, 2013.

4. Full-time employees hired into the County on or after January 1, 2016 will not be eligible for Employer provided retiree medical, prescription drug, dental or vision coverage and life insurance.

5. Retired employees and/or their eligible spouse as defined in D.1.a., shall apply and participate in the Medicare Program, if eligible, at their expense as required by the Federal Insurance Contribution Act, a part of the Social Security Program. At that time the Employer's obligation shall be only to provide medical and prescription drug coverage that will coordinate or supplement with Medicare. Failure to participate in the aforementioned Medicare Program shall be cause for termination of Employer paid coverage of applicable hospital-medical benefits, as outlined herein for employees who retire and/or their eligible spouse as defined in D.1.a.

6. Employees who retire under the provisions of the Macomb County Employees' Retirement Ordinance and eligible spouse as defined in D.1.a., shall, if eligible apply for and participate in ANY National Health Insurance program offered by the U.S. Government. Failure to participate, if eligible, shall be cause for termination of Employer paid hospital-medical benefits as outlined.

7. Retirees who are eligible for Macomb County's medical and prescription drug plan and elect not to participate and who has coverage provided elsewhere, shall receive a monthly insurance waiver payment of $167.00. The insurance waiver will be paid in the retiree's regular retirement check.

   a. Retirees shall establish proof of their eligibility to receive the insurance waiver.

   b. Retirees participating in the insurance waiver who lose coverage shall be allowed to enroll in Macomb County's medical and prescription drug plans as soon as administratively possible and the insurance waiver payments shall cease as soon as administratively possible.

E. Dental Plan:

The Employer shall provide a dental plan to full-time employees (including DROP Participants) and their eligible dependents as outlined in Appendix D, Active Employees Dental Benefits, or its substantial equivalence.

F. Vision Plan:

The Employer shall provide a vision plan to full-time employees (including DROP Participants) and their eligible dependents as outlined in Appendix E, Active Employees Vision Benefits or its substantial equivalence.

G. Liability Insurance: The County shall provide for each regular employee (including DROP Participants) Bodily Injury and Property Damage Liability Insurance while acting within the scope of his/her duties and Personal Injury Insurance including "false arrest" when also arising out of and in the line of duty and in the conduct of duly constituted Employer business. The cost of this insurance will be borne by the Employer.

H. Long Term Disability: Full-time employees (including DROP Participants) covered by this Agreement will be provided a Long Term Disability program with benefits as currently provided by the present provider, or its substantial equivalence.

I. The County shall provide, at its discretion, a Voluntary Benefit Program to include, but not limited to, supplemental life insurance, pet insurance, critical care insurance, short term disability and legal services. The Employer will provide a payroll deduction for employees (including DROP participants) wishing to purchase these voluntary benefits.

J. Part-time employees shall not be eligible for Macomb County's medical, prescription drug, dental and vision plans, life insurance, Voluntary Benefit Program and long term disability during employment and/or upon retirement.

ARTICLE 10

JOB POSTINGS

A. Postings shall be made for a minimum of five (5) working days. Posting periods may be shortened or eliminated by agreement of the Parties.

B. The posting will include the following information: The job classification, department, salary range, hours, starting time, qualifications and any testing requirements.

C. Any employee interested in a position must apply through the Human Resources and Labor Relations established application process within the posting period. The employee must meet the minimum qualifications before the closing date of the posting, unless otherwise specified by Human Resources and Labor Relations or this collective bargaining agreement.

D. If necessary, a temporary appointment may be made by the Department Head.

ARTICLE 11

JURY DUTY

In the event an employee is called for jury duty, the employee shall promptly provide a copy of the official notice to his/her immediate supervisor. The employee's schedule may be adjusted by the Employer, provided, however, no employee shall be required to work any number of hours, when added to the number of hours the person spends on jury duty, that exceeds the number of hours normally and customarily worked by the person during a work day. An employee working second shift, whose schedule has not been adjusted, shall be released from the shift scheduled for the same date as the scheduled jury duty. An employee working third shift, whose schedule has not been adjusted, shall normally be released from the shift scheduled on the date prior to the scheduled jury duty, except, with approval of the Department, an employee may be released from the scheduled shift on the date after the scheduled jury duty.

Should any employee be released from jury duty prior to the end of that shift, the employee shall, when practicable, return to the department and work until the conclusion of that day's shift.

The employee shall be paid his/her normal daily wage for each day worked and/or assigned to jury duty. The employee shall pay to the Employer an amount equal to any payment received as a result of jury duty service. Expenses provided to employees as a result of jury duty service, such as mileage, parking or meal expenses, may be retained by the employee.

ARTICLE 12

LEAVE OF ABSENCE

A. Full-time employees are eligible and may request a leave of absence in writing for any of the following reasons:

1. Personal Leave
2. Medical Leave for Employee and/or Family
3. Military

B. Provisions:

1. Personal Leave:

a. An employee may be eligible for a Personal Leave upon completion of 12 months of service from their date of hire.

b. An employee absent from work for more than 15 consecutive working days shall be required to apply for and submit a request for Personal Leave in writing using forms required by Human Resources and Labor Relations.

c. All requests for a Personal Leave must be submitted at least thirty (30) days prior to the effective date of the Personal Leave.

d. While on an approved Personal Leave, an employee must exhaust annual leave/paid time off and compensatory time.

e. An employee approved for a Personal Leave shall not accrue credited service for retirement during the time which the employee is on said Personal Leave without pay.

f. While on an unpaid Personal Leave, benefits will be cancelled at the end of the month from the point of unpaid status. Upon return from an unpaid Personal Leave of Absence, insurance benefits will be reinstated in accordance with the waiting periods as outlined in Article 9, Insurance Benefits.

g. The Department Head/designee and the Director, Human Resources and Labor Relations/designee shall approve or disapprove all requests for Personal Leave.

h. An employee that fails to report for duty upon expiration of a Personal Leave shall be subject to loss of seniority.

2. Medical Leave for Employee and/or Family:

a. An employee may be eligible for a Medical Leave upon completion of 6 months of service from their date of hire.

b. An eligible employee who is unable to work due to their own medical condition caused by an illness or injury or the medical condition of a family member caused by illness or injury may request a Medical Leave.

c. A family member shall be defined as parent, current step parent, current spouse, children, current step children, brother, sister, grandparent or grandchild. It shall also include any person who is normally a member of the employee's household.

d. An employee absent from work for more than 5 consecutive working days shall be required to apply for and submit a request for Medical Leave in writing using forms required by Human Resources and Labor Relations.

e. All foreseeable requests for a Medical Leave must be submitted in writing to the Department Head or designee at least thirty (30) days prior to the effective date of the Medical Leave.

f. An eligible employee must complete a request for Medical Leave of Absence and Certification of Health Care Provider form provided by the U.S. Department of Labor.

g. Medical certification must be received in the Human Resources and Labor Relations Department within 15 days from the employee's last day worked.

h. While on an approved Medical Leave, an employee must exhaust sick leave and compensatory time.

i. Medical Leave extension requests must be submitted in writing at least 5 working days prior to the

expiration of the current approved Medical Leave.

j. An employee on an approved unpaid Medical Leave shall not accrue credited service for retirement during the time which the employee is on said Medical Leave without pay.

k. While on an unpaid Medical Leave, benefits will be cancelled at the end of the month following six (6) months of unpaid status.

Upon the return from the unpaid Medical Leave, benefits will be reinstated effective immediately.

l. The Employer may exercise the right to have the employee examined by a physician selected by the Employer before approving and granting such request for Medical Leave and/or Medical Leave extension at the Employer's expense.

m. The Department Head/designee and the Director, Human Resources and Labor Relations/designee shall approve or disapprove all requests for Medical Leave.

n. In order to return from a Medical Leave, the employee must have the ability to perform the essential functions of the job with or without reasonable accommodation. At the Employer's sole discretion, a medical examination may be conducted at the Employer's expense.

o. Failure to report for duty upon expiration of a Medical Leave shall be subject to loss of seniority.

3. Military:

a. The Employer complies with the Uniform Services Employment and Reemployment Right Act (USERRA), 38 USC, Chapter 43 Employment and Reemployment Rights of Members of the Uniformed Services. An employee whose absence from employment is necessitated by reason of duty in the uniformed services, shall notify the Elected Official/Department Head or designee of the upcoming military service requirements.

b. Benefits provided for employees absent under this Article shall be provided consistent with the Uniform Services Employment and Reemployment Right Act (USERRA), 38 USC, Chapter 43 Employment and Reemployment Rights of Members of the Uniformed Services as determined by Human Resources and Labor Relations. Employees absent under USERRA should provide the County with a copy of their military orders.

c. Any employee on an approved USERRA Military Leave of Absence shall be eligible for the following benefits as a result of their Military Leave of Absence: differential pay, medical, prescription drug, dental and vision benefits, life insurance, Retirement eligibility or 401(a) vesting, Sick Leave, Paid Time Off (PTO) and Longevity as determined by Human Resources and Labor Relations.

4. Family And Medical Leave Act: The Employer shall comply with all aspects of the Family and Medical Leave Act (FMLA). Leaves will run concurrent with any FMLA eligible Leave.

ARTICLE 13

LONGEVITY

A. Participants in the Deferred Retirement Option Plan are not subject to Article 13, Longevity, but shall receive Longevity in the manner described in Article 22, Deferred Retirement Option Plan.

B. The Parties recognize employees who have a record of long continued employment and service with the County of Macomb and value the experience gained through such length of service.

C. The basis of longevity compensation is as follows:

1. Eligibility of a full-time employee shall commence when such employee shall have completed fifteen (15) years of continuous full-time employment on or before October 31st of any year.

2. Continuous employment shall not be considered interrupted when absences arise as paid vacations, paid Sick Leave, approved Leave of Absence and/or paid Worker's Compensation period not to exceed one year.

3. The following schedule shall be used as a basis for longevity payments, paid to such employees as of October 31st, provided said employees qualify as to length of service, as per Paragraph C.1 of this Article, as follows:

STEP	CONTINUOUS YEARS OF FULL TIME SERVICE ON OR BEFOR OCTOBER 31 OF EACH YEAR	AMOUNT
1	15 through 19	$600
2	20 through 24	$800
3	25 and thereafter	$1,000

D. Longevity compensation shall be added to the regular payroll check, when due, for eligible employees. It shall be considered a part of the regular compensation and, as such subject to Federal and State withholding tax, social security, retirement deductions, regulations and ordinances of the County of Macomb and other applicable statutes.

E. Payments to employees eligible as of October 31st of any year shall be included in the first regular payroll check of December. The annual period covered in computation of longevity shall be from November 1 of each year through and including October 31st of the following year.

F. Employees leaving the employ of the County by reason of retirement and receiving benefits under the Macomb County Employees' Retirement Ordinance, or by reason of death from any cause shall be entitled to and receive a longevity payment upon a pro-rated basis for that portion of the year employed.

G. Employees hired into the County after January 1, 2012 will not be eligible for Longevity.

ARTICLE 14

MANAGEMENT RIGHTS

A. The Employer retains and shall have the sole and exclusive right and authority to manage and operate its affairs, including all of its operations and activities; to decide the number of employees; to establish the overall operation, policies and procedures of the Employer; to assign employees to shifts in order to adequately staff shifts with appropriate personnel; to schedule the shifts of all employees; to direct its working force of employees; to determine the methods, procedures and services to be provided; to comply with P.A. 390, as amended, known as the State's Emergency Management Act and the County's Emergency Management resolution as well as all related plans, policies and procedures covered by these statutes. All of such rights are vested exclusively in the Employer.

B. The Employer, in addition to the rights set forth in Section A above, shall have the right to hire, promote, demote, assign, transfer, suspend, discipline, discharge, layoff, recall; to establish schedules of work for employees; to establish work rules and rules of conduct, and to fix and determine penalties for the violation of such rules; to maintain discipline and efficiency among the employees, provided that such rights shall not be exercised by the Employer in violation of any of the express terms and provisions of this Agreement.

C. The Employer retains and shall have the sole and exclusive right to administer, without limitation, implied or otherwise, all matters not specifically and expressly covered by the provisions of Paragraph A and B of this Article, or accepted by the provisions of any other Article of this Agreement.

D. The Employer retains and shall have the sole and exclusive right and authority to convert full time vacant positions to part time.

ARTICLE 15

MILEAGE

Mileage reimbursement will be made for employees required to use their personal vehicles while performing assigned County business. The mileage reimbursement rate will be established in accordance with the Internal Revenue Service mileage reimbursement formula. Mileage reimbursement will be paid based on the rate in effect at the time the mileage was incurred.

Mileage reimbursement must be authorized in advance by the Department Head or designee and in accordance with County and Department Policy.

ARTICLE 16

OVERTIME

A. Full-time employees shall receive compensation at the rate of 1 ½ times their regular hourly rate for all hours scheduled and authorized over and above their regular work week. Compensation as used in this Article shall mean either cash payment or compensatory time. The Employer has the right to offer overtime compensation either in the form of cash payment or compensatory time. An employee has the right to refuse overtime if it is offered as compensatory time; however, the Employer may then offer the overtime, in the form of compensatory time, to other employees. There shall be no accrual of compensatory time in excess of 40 hours. Employees may request to be paid for unused compensatory time and the County shall, within thirty (30) days of such request, pay the employee for unused compensatory time.

B. All overtime shall be distributed in accordance with the Medical Examiner Call-In Procedure 2016-5.

C. All overtime shall be paid at the employee's hourly rate at the time the overtime was worked.

D. An employee called into work prior to the start of their assigned shift or required to stay at work beyond their assigned shift, as directed and approved by management, will receive compensation at the rate of 1 ½ times their regular hourly rate for the time beyond their assigned shift.

E. General Conditions:

1. In case of an emergency an employee may be required to work beyond his/her regular shift.

2. The Employer will attempt to notify the employee but is not required to make repeated efforts to contact an employee for specific overtime.

ARTICLE 17

PAID TIME OFF

A. Participants in the Deferred Retirement Option Plan are not subject to Article 17, Paid Time Off, but shall receive Paid Time Off in the manner described in Article 22, Deferred Retirement Option Plan.

The purpose of Paid Time Off (PTO) is to provide employees with flexible paid time off from work that shall be used for such employee needs as vacation, personal business and other activities, without disrupting the operations of the department. Paid Time Off (PTO) shall also be used for employee absences incurred from inclement weather.

B. Full time employees shall be entitled to accrue Paid Time Off (PTO) according to the following schedule.

The paid leave provisions in this contract apply only to full time employees working 37.5 hours or more. All other employees accrue paid leave time in accordance with Michigan's paid leave act and that leave time will be administered according to the acts provisions (PA 338 of 2018 as amended).

YEARS OF CONSECUTIVE FULL TIME SERVICE COMPLETED:	ANNUAL EQUIVALENT OF:
less than 5	15 days (112.5 hours)
5	20 days (150 hours)
10	21 days (157.5 hours)
13	24 days (180 hours)
20	25 days (187.5 hours)
21	26 days (195 hours)
22	27 days (202.5 hours)
23	28 days (210 hours)
24	29 days (217.5 hours)
25	30 days (225 hours)

C. Paid Time Off days may be accumulated to a maximum of thirty (30) days (225 hours).

D. Paid Time Off shall be available for use upon accrual.

Full-time employees, except for participants in the Deferred Retirement Option Plan (DROP), shall be entitled to accumulate Paid Time Off as above for each fully paid two (2) week pay period of service. Paid Time Off shall accumulate only on hours paid.

E. Paid Time Off requests shall be reviewed by the Department Head/designee, and must have their approval. Such approval shall be at the Department Head/designee's discretion to ensure efficient operations.

F. Full time employees, including participants in the Deferred Retirement Option Plan (DROP), may request Paid Time Off conversion to cash payment of up to forty (40) hours per conversion, maximum of eighty (80) hours per year. Employees requesting Paid Time Off conversion must have a minimum of one hundred twenty (120) hours of Paid Time Off to be eligible for the conversion. The requested Paid Time Off conversion(s) must be submitted by February with the cash payment to be made on the second pay in March and August with the cash payment to be made on the second pay in September in a regular paycheck with normal deductions.

G. Upon termination of employment, an employee shall be compensated for their Paid Time Off at the rate of pay said employee received at the time of termination.

ARTICLE 18

PROBATIONARY PERIOD

A. Probationary Period For New Full-time Employees: All full-time employees newly hired into this bargaining unit shall be required to successfully complete a probationary period; the length of said probationary period shall be the first six (6) months of employment from the date of hire. During the probationary period of a new employee, s/he may be terminated at any time without the right of appeal or a statement of cause.

B. Probationary Period For New Part-time Employees: All part-time employees newly hired into this bargaining unit shall be required to successfully complete a probationary period; the length of said probationary period shall be the first nine (9) months of employment from the date of hire. During the probationary period of a new employee, s/he may be terminated at any time without the right of appeal or a statement of cause.

C. Probationary Period For Employees Who Have Had a Change in Classification: Employees in this bargaining unit who have had a change in classification (promotion, demotion, lateral transfer, bump or recall) shall serve a probationary period of four (4) months from the date of change in classification. Employees who have had a change in classification shall have the opportunity to return to their prior classification within one (1) month from the date of change in classification. During the probationary period of an employee who has had a change in classification, the employee may be returned to his/her former classification at any time without the right of appeal or statement of cause. Such decision shall be within the sole discretion of the Employer.

ARTICLE 19

RECOGNITION

Pursuant to and in accordance with all applicable provisions of Act 379 of the Public Acts of 1965, as amended, the Employer does hereby recognize the Union as the sole and exclusive representative for the purpose of collective bargaining with respect to wages, hours and other terms and conditions of employment for the term of this Agreement for all classifications (full-time or part-time) of Medical Examiner Investigator provided it is agreed and understood that the County of Macomb does not, by entering into this Agreement, purport to assume control or exercise jurisdiction in those areas where statutory and constitutional powers have been exclusively vested in County or State elected and/or appointed officials.

ARTICLE 20

REPRESENTATION

A. The Union shall notify the Employer in writing of the name(s) of the Officer and Steward for their bargaining unit. In the event there is a change in the Officer or Steward, the Union shall inform the Employer forty-eight (48) hours prior to such Union Officer or Steward taking over their duties.

B. The Employer agrees to recognize one (1) Officer and one (1) Steward for the bargaining unit.

C. The bargaining unit will be permitted a maximum of one (1) hour per calendar week during their working hours, without loss of time or pay, for the purpose of investigating and presenting grievances to the Employer. A greater period of time may be permitted by prior authorization from their immediate Supervisor or the Department.

D. Bargaining Committee:

1. The Bargaining Committee shall be comprised of two (2) local union members and a T.P.O.A.M. representative.

2. The Bargaining Committee shall be released from regular duty and compensated for all time spent negotiating during the member's regular work schedule.

ARTICLE 21

RETIREMENT SYSTEM

A. Retirement Benefits: The Employer shall continue the benefits as provided by the presently constituted Macomb County Employee's Retirement Ordinance, and the Employer and the employee shall abide by the terms and conditions thereof, provided, that the provisions thereof may be amended by the Retirement Board as provided by the statutes of the State of Michigan and provided further, that an annual statement of employee's contributions is available upon request.

B. Full-time employees hired into the County prior to January 1, 2016:

1. Employee Contribution: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the employee's contribution to the retirement system is three and five tenths

percent (3.5%) of their compensation.

For employees hired on or after January 1, 2002 the employee's contribution to the retirement system is two and five tenths percent (2.5%) of their compensation.

2. County Pension Maximum: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the County pension shall not exceed sixty-five percent (65%) of annual average compensation.

   For employees hired on or after January 1, 2002, the County pension shall not exceed sixty-six percent (66%) of an employee's final average compensation.

3. Pension Multiplier: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the pension multiplier is two and four tenths percent (2.4%) for the first twenty-six (26) years of credited service and one percent (1%) for each year of credited service thereafter.

   For employees hired on or after January 1, 2002, the pension multiplier is two and two tenths percent (2.2%) for all years of credited service.

4. Final Average Compensation Formula: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the formula for computing final average compensation, used for calculating pension benefits for eligible bargaining unit members, shall be based on the average of an employee's one hundred and four (104) highest consecutive pay periods of compensation out of the last two hundred and sixty (260) pay periods.

   For employees hired on or after January 1, 2002, the formula for computing final average compensation, used for calculating pension benefits for eligible bargaining unit members, shall be based on the average of an employee's one hundred and thirty (130) highest consecutive pay periods of compensation out of the last two hundred and sixty (260) pay periods.

   Retroactive Effect: Notwithstanding the provisions of the Macomb County Employees' Retirement System Ordinance, when an employee's Final Average Compensation is calculated, any retroactive wages provided shall be counted as if the retroactive wages were paid to the employee when the wages were paid, not when they were earned by the employee.

5. Pension Calculation: For any employee hired on or before December 31, 2001, or who is vested as of February 27, 2009, the County pension, which when added to an employee pension, will provide a straight life retirement allowance equal to the number of years, and fraction of a year, of an employee's credited service multiplied by the sum of 2.4% of the employee's final average compensation for the first twenty-six (26) years of credited service and one percent (1%) for each year of credited service thereafter.

   For employees hired after January 1, 2002, the County pension, which when added to an employee pension, will provide a straight life retirement allowance equal to the number of years, and fraction of a year, of an employee's credited service multiplied by the sum of 2.2% of the employee's final average compensation for all years of credited service.

   Effective January 1, 2020 in no case shall the Straight Life pension benefit for a bargaining unit member under this contract exceed 100% of the employee's base salary at the time of retirement. Such limitation shall be applied to a bargaining unit member's straight life benefit calculation prior to an applicable actuarial adjustment, if any, for the member's selection of an optional form of benefit or the annuity withdrawal option and shall also apply to the member's DROP benefit.

6. Eligibility:

   a. For employees hired on or before December 31, 2001, or who is vested as of February 27, 2009, who meets the following criteria may retire upon the employee's written application filed with the

Retirement Board:

1. Attained age 60 years and has 8 or more years of credited service; or

2. Attained the age of 50 with at least 8 years of credited service, if the employee's age, when added to the employee's years of credited service, equal the sum of 70 or more.

b. For employees hired on or after January 1, 2002, any member who meets the following criteria may retire upon their written application filed with the Retirement Board:

1. Attained age 60 years and has 8 or more years of credited service; or

2. Attained the age of 55 with 25 years of credited service.

c. For employees hired into the County on or after January 1, 2012, any member who meets the following criteria may retire upon the employee's written application filed with the Board:

1. Attained age 60 years and has 15 or more years of credited service; or

2. Attained the age of 55 with 25 years of credited service.

Upon the employee's retirement, the employee shall receive a pension as provided in the Retirement Ordinance.

d. In the event a former member is re-employed by the County as a full-time employee within four (4) years from their last separation date, membership is reinstated.

1. For employees who have multiple terms of employment as a member in Macomb County Employees' Retirement System, the following shall apply:

a. If an employee was vested during the first term of employment, the pension will be calculated per the terms of the original date of hire.

b. If an employee was not vested during the first term of employment, the pension will be calculated per the terms of the employee's rehire date.

e. In the event a former member is re-employed by the County as a full-time employee and it has been four (4) or more years since their last separation date, their membership will not be re-instated, and they will enter the 401(a) Defined Contribution plan.

7. Annuity Withdrawal: Members of the Macomb County Employees' Retirement System may elect to take an Annuity Withdrawal, excluding non-duty disability retirement and non-duty death. The utilization of this option shall be governed by any applicable Annuity Withdrawal provisions of the Macomb County Employees' Retirement System Ordinance.

8. Purchase of Military Service Credits: A member who wishes to purchase military service credits as provided in the Macomb County Employees' Retirement Ordinance shall be allowed to purchase to purchase military service credit through payroll deduction.

If a member chooses the payroll deduction option, the cost of such credit shall be computed as provided in the aforementioned Ordinance.

9. Option D: A retirant shall have the option of selecting survivor's benefits in conjunction with the retirement option described in the Macomb County Employees' Retirement Ordinance commonly known as "Option D – Level Income Option". Said survivor's benefits shall correspond to those benefits known as Option A – 100% Survivor Allowance, Option B – 50% Survivor Allowance and Option C – Allowance for 10 Years Certain and Life Thereafter, as described in the Ordinance.

10. Pop Up Option: A retirant may elect this option in combination with Option A or B of the Ordinance. Under this option, a reduced retirement allowance is payable during the joint lifetime of the retirant and their beneficiary nominated under Option A or B, whichever is elected. Upon the death of the retirant, their beneficiary will receive a retirement allowance for life equal to the percentage specified by Option A or B of the reduced retirement income payable during the joint lifetime of the retirant and their beneficiary. Upon the death of the beneficiary, the retirant will receive a retirement allowance equal to one hundred percent of the amount specified by the Macomb County Employees' Retirement Ordinance for the remaining lifetime of the retirant. The reduced retirement allowance payable during the joint lifetime of the retirant and their beneficiary together with the retirement allowance payable to one upon the death of the other will be actuarially equivalent to the retirement allowance provided by the Macomb County Employees' Retirement Ordinance as a single life annuity. This provision shall be without force or effect unless or until the retirant submits acceptable documentation of the death of their beneficiary to the Secretary of the Retirement Board.

11. Deferred Retirement Allowance Option: In the event a vested bargaining unit member, leaves the employ of the County prior to the date they have satisfied the age and service requirements for retirement provided in the Macomb County Employees' Retirement Ordinance, for any reason except their disability retirement or death, they shall be entitled to retire at the normal retirement age and be subject to the retirement formula in effect at the time they left County employment and as provided for in the Macomb County Employee's Retirement Ordinance, provided that they do not withdraw their accumulated contributions from the employees savings fund. Their retirement allowance under the plan in effect at the employee's termination of County employment shall begin the first day of the calendar month next following the date their application for same is filed with the Board after the employee would have become eligible for retirement under the plan had the employee's employment not been terminated, but not later than 90 days after the employee becomes 65 years of age.

    A vested former member who withdraws accumulated member contributions and voluntarily forfeits credited service in the System thereby forfeits all rights in and to the portion of the pension attributable to the forfeited credited service.

    There shall be no pension paid to an eligible vested former member until an application for retirement is submitted and approved. In the event an eligible vested member dies prior to applying for their pension, their beneficiary or estate/trust shall not be entitled to a pension. The vested member's beneficiary or estate/trust shall receive the contributions and interest earned as of the date of the vested member's death.

12. Non-Duty Death Before Retirement, Beneficiary Nominated: Any bargaining unit member who is vested may at any time prior to the effective date of their retirement elect Option A provided in the Macomb County Employees' Retirement System Ordinance in the same manner as if they were then retiring from county employment, and nominate a beneficiary whom the Retirement Board finds to be dependent upon the said member for at least 50 percent of their support due to lack of financial means. Prior to the effective date of their retirement a member may revoke their said election of Option A and nomination of beneficiary and they may again elect the said Option A and nominate a beneficiary as provided in this section. Upon the death of a member who has an Option A election in force their beneficiary, if living, shall immediately receive a retirement allowance computed in the same manner in all respects as if the said member had retired the day preceding the date of their death, notwithstanding that they might not have attained age 60 years. If a member has an Option A election in force at the time of their retirement their said election of Option A and nomination of beneficiary shall thereafter continue in force; provided, that prior to the effective date of their retirement, they shall have the right to elect to receive their retirement allowance as a straight life retirement allowance or under Option B provided in the Ordinance. No retirement allowance shall be paid under this section on account of the death of a member if any benefits are paid or will become payable under the Ordinance on account of their death.

13. Non-Duty Death Before Retirement, Non-spousal Beneficiary Nominated: In the event of a non-duty death of a vested member prior to retirement, a non-spousal beneficiary shall receive only contributions

and interest.

14. Non-Duty Death Retirement Allowance, Automatic Provisions: Any vested bargaining unit member who continues County employment and (1) dies while in County employment and (2) leaves a spouse, the spouse shall immediately receive a retirement allowance computed in the same manner in all respects as if the member had (1) retired the day preceding the date of the members death, notwithstanding that the member might not have attained age 60 years, and (2) elected Option A in the Macomb County Employees' Retirement Ordinance.

15. Deferred Retirement Option Plan (DROP): The Memorandum of Understanding executed in 2007 regarding the Deferred Retirement Option Plan (DROP) is incorporated by reference herein as Article 22, Deferred Retirement Option Plan. Vesting for the purposes of DROP excludes service time under Reciprocal Act 88.

C. Full-time employees hired into the County on or after January 1, 2016:

1. Will be eligible to receive a one-time fixed payment of $1000 from the Macomb County Employees' Retirement System. This payment will be made to an employee after separation from employment and who meets the Employer contribution vesting requirements as outlined in Section C.5 and after the completion of five (5) years of service.

2. Will not be eligible for or participate in the Macomb County Employees' Retirement System for any other benefit, including DROP, other than for the fixed payment as outlined in Section C.1.

3. Will participate in a Defined Contribution Retirement Plan. Employees shall contribute three percent (3%) of the employee's base pay and the Employer shall contribute six percent (6%) of the employee's base pay.

   Upon the completion of 5 years of actual service with the Employer, employees shall be eligible to elect to increase their contribution by one percent (1%) of the employee's base pay. Per IRS regulations, the additional one percent (1%) contribution is a post-tax contribution. If such election is made by the employee, the Employer shall increase its contribution from six percent (6%) to eight percent (8%) of the employee's base pay.

4. Will not be eligible for Employer provided retiree medical, prescription drug, dental or vision coverage and life insurance. The eligible employee, however, shall receive $100 per pay period, deposited by the County, into the Defined Contribution Retirement Plan, not to exceed $2600 per year.

5. Employees shall have the following schedule as it relates to vesting for the Employer contributions:

Completion of 1 year of service	20%
Completion of 2 years of service	40%
Completion of 3 years of service	60%
Completion of 4 years of service	80%
Completion of 5 years of service	100%

ARTICLE 22

DEFERRED RETIREMENT OPTION PLAN

Eligible employees may elect to participate in the Deferred Retirement Option Plan (DROP). Eligibility, terms, and conditions of DROP participation are set forth below, including the payment of certain fringe benefits to DROP participants, Longevity, Paid Time Off and Sick Leave.

A. Eligibility: An employee who is a member of the Macomb County Employees' Retirement System may voluntarily elect to participate in the DROP with a minimum of a thirty (30) day notice, at any time after attaining the minimum age and service requirements for a normal service retirement. Vesting for the purposes of DROP excludes service time under Reciprocal Act 88.

B. Participation: The maximum period for DROP payments credited to the account is five (5) years (the "Participation Period"). There is no minimum time period for participation. Employees may continue to work beyond the five (5) years, but DROP payments will cease at the end of the participation period.

C. DROP Payment: Upon termination of employment, the retiree shall receive the monthly pension previously credited to their DROP account. Failure to terminate employment at the expiration of the DROP Participation Period shall result in forfeiture of the employee's monthly pension ~~benefit~~ otherwise payable to the DROP account. Interest on the DROP account will continue to accrue during such a forfeiture.

D. Election to Participate: Participation in the DROP is irrevocable once an employee begins participation. An employee who wishes to participate in the DROP shall be eligible to begin at the start of a pay period and must complete and sign such application form. Such application shall be reviewed by the Human Resources and Labor Relations Department within a reasonable time period and a determination shall be made as to the member's eligibility for participation in the DROP. On the date upon which the member's participation in the DROP shall be effective, they shall be considered to be a DROP participant and shall cease to be an active member of the Macomb County Employees Retirement System. The amount of credited service, multiplier and final average compensation shall be fixed as of the employee's DROP date. When an employee's Final Average Compensation is calculated, any retroactive wages provided shall be counted as if the retroactive wages were paid to the employee when the wages were paid, not when they were earned by the employee. Increases or decreases in compensation during DROP participation will not be factored into retirement benefits of active or former DROP participants. DROP participants accrue no service time credit for retirement purposes pursuant to the Macomb County Employees Retirement System.

E. DROP Account: The employee's DROP Account shall be the regular monthly pension with interest to which the employee would have been entitled if they had actually retired on the DROP date. The payment shall be credited monthly to the employee's individual DROP account. At the time an employee elects to participate in the DROP, their optional form of retirement allowance as set forth in the Macomb County Employee Retirement Ordinance shall be irrevocable. All individual DROP accounts shall be maintained for the benefit of each employee participating in the DROP and will be managed by the Retirement System in the same manner as the primary retirement fund. DROP interest for each employee who participates in the DROP shall be at a fixed rate of 3.5% per annum, calculated in the same manner as the interest in the employee savings accounts in the Macomb County Employees Retirement System.

F. Annuity Withdrawal: An employee who elects to participate in the DROP may elect the Annuity Withdrawal option provided by the retirement ordinance at the time of electing DROP participation. Such election shall be made commensurate with the employee's DROP election, but not thereafter. Such annuity withdrawal will be utilized to compute the actuarial reduction of the member's DROP benefit, as well as the member's monthly pension from the Macomb County Employees Retirement System, after termination of employment.

The annuity withdrawal amount (accumulated contributions and interest) will be disbursed from the Macomb County Employees Retirement System within sixty (60) days from the first pension check. All withdrawal provisions and options under the Retirement Ordinance, which are available to Retirement System members shall be available to the employee participating in the DROP at such time that they elects to participate in the DROP.

G. Contributions: The employee's contributions to the Macomb County Employees Retirement System shall cease as of the date that the employee begins participation in the DROP.

H. Distribution of DROP Account: The employee participating in the DROP must choose one, or a non-inconsistent combination of, the following distribution methods to receive payment(s) from their individual DROP account:

1) A lump sum distribution to the employee; AND/OR

2) A lump sum direct rollover to another qualified plan to the extent allowed by federal law and in accordance with any procedures established by the Retirement System for such rollovers.

Failure to elect one of the above options and receive such distribution within 60 days of termination of employment shall result in a lump sum distribution to the employee.

I. Death During DROP Participation: If an employee participating in the DROP dies either: (1) before full retirement, that is before termination of employment with the County, or (2) during full retirement (that is, after termination of employment with the County but before the DROP account balance has been fully paid), the employee's designated beneficiary(ies) shall receive the remaining balance in the employee's DROP account in the manner in which they elect from the previously mentioned distribution methods (above). If there is no such beneficiary, the account balance shall be paid in a lump sum to the estate/trust of the employee. Benefits payable from the Macomb County Employees Retirement System shall be determined as though the employee participating in the DROP had separated from service on the day prior to the employee's date of death.

J. Disability During DROP Participation: In the event an employee participating in the DROP becomes totally and permanently disabled from further service in the employment of Macomb County, the employee's participation in the DROP shall cease, and the employee shall receive such benefits as if the employee had retired and terminated employment during the participation period.

K. Internal Revenue Code Compliance: The DROP is intended to operate in accordance with Section 415 and other applicable laws and regulations contained within the Internal Revenue Code of the United States. Any provision of the DROP, or portion thereof, that is in conflict with an applicable provision of the Internal Revenue Code of the United States is hereby null and void and of no force and effect.

L. Other Provisions: The Macomb County Employees Retirement System is a defined benefit plan. Should that plan be modified to include a defined contribution plan, this DROP account established is only part of a defined benefit plan. It is intended that this DROP be a "forward" DROP only and contains no DROP "back" provision, which would allow members to retire retroactively.

O. Paid Time Off and Sick Leave in Final Average Calculation: The collective bargaining agreement may provide for the crediting of both Paid Time Off and Sick Leave banks for inclusion in determining an employee's final average compensation for purposes of computing an employee's pension.

At the effective date of an employee's participation in the DROP, an employee's Paid Time Off and Sick Leave bank shall be "credited" and/or paid as provided for in the collective bargaining agreement or the Macomb County Employees Retirement Ordinance.

After the effective date of an employee's participation in the DROP, the employee's Paid Time Off and Sick Leave shall be determined as set forth in the collective bargaining agreement.

N. Longevity, Paid Time Off and Sick Leave: After the effective date of an employee's participation in the DROP, the employee's Longevity, Paid Time Off and Sick Leave shall be determined as set forth below.

1. Longevity for DROP Participants:

a. At the time an employee elects to participate in the DROP they shall receive, as part of their payoff, a prorated amount of longevity compensation. Payment for the balance of the DROP

years' longevity payment and subsequent longevity payments shall be made in December of each year as described below.

b. For DROP participants, the amount of longevity compensation paid in subsequent years shall be determined by the step level achieved by the employee at the time they elected to DROP. Step levels are listed below.

STEP	CONTINUOUS YEARS OF FULL TIME SERVICE ON OR BEFORE OCTOBER 31ST OF EACH YEAR	AMOUNT
1	15 through 19	$600
2	20 through 24	$800
3	25 and thereafter	$1,000

c. Longevity compensation shall be added to the regular payroll check, when due, for eligible DROP participants. It shall be considered a part of the regular compensation and, as such subject to Federal and State withholding tax, social security, regulations and ordinances of the County of Macomb and other applicable statutes.

d. Payments to eligible DROP participants as of October 31st of any year shall be included in the first regular payroll check of December. The annual period covered in computation of longevity shall be from November 1 of each year through and including October 31st of the following year.

e. DROP participants who terminate employment shall be entitled to and receive a longevity payment upon a pro-rated basis for that portion of the year employed.

2. Paid Time Off for DROP Participants

a. The purpose of Paid Time Off (PTO) is to provide employees with flexible paid time off from work that shall be used for such employee needs as vacation, personal business and other activities, without disrupting the operations of the department. Paid Time Off (PTO) shall also be used for employee absences incurred from inclement weather.

b. Employees who are participants in the Deferred Retirement Option Plan (DROP) shall receive Paid Time Off in the following manner.

DROP participants shall receive, on January 1st of each year of DROP participation, a number of hours of Paid Time Off equal to the number of hours of Paid Time Off earned based upon their years of service at the commencement of DROP participation according to the following schedule:

YEARS OF CONSECUTIVE FULL-TIME SERVICE COMPLETED:	ANNUAL EQUIVALENT OF:
less than 5	15 days
5	20 days
10	21 days
13	24 days
20	25 days
21	26 days
22	27 days
23	28 days
24	29 days
25	30 days

c. Paid Time Off requests shall be reviewed by the Department Head/designee, and must have their approval. Such approval shall be at the Department Head/designee's discretion to ensure efficient operations.

d. DROP participants may request Paid Time Off conversion to cash payment of up to forty (40) hours per conversion, maximum of eighty (80) hours per year. Employees requesting Paid Time Off conversion must have a minimum of one hundred twenty (120) hours of Paid Time Off to be eligible for the conversion. The requested Paid Time Off conversion(s) must be submitted by February with the cash payment to be made in the second pay in March and August with the cash payment to be made in the second pay in September in a regular paycheck with normal deductions.

e. Employees whose DROP participation begins at a time of year other than January 1st, shall receive a pro-rata share of Paid Time Off for the balance of the calendar year computed in the same manner as paragraph b. above.

f. Paid Time Off not utilized by an employee by December 31st of a calendar year shall be forfeited.

g. There shall be no compensation for Paid Time Off remaining in the DROP participant's Paid Time Off bank upon separation from employment.

h. DROP participants who utilize Paid Time Off in an amount in excess of a proportionate share prior to voluntarily or involuntarily discontinuing employment shall be obligated to compensate the Employer for all Paid Time Off time used in excess of such proportionate share. This provision shall not apply to a DROP participant whose involuntary discontinuance of employment is caused by duty related death or disability.

3. Sick Leave for DROP Participants:

a. DROP participants shall be provided with six (6) days of Sick Leave on January 1st of each year the employee participates in the DROP.

b. Employees who begin DROP participation at a time other than January 1st, shall receive a pro-rata share of six (6) Sick Leave days for the balance of the calendar year.

c. After the exhaustion of the six (6) Sick Leave days provided for in paragraph a., above, DROP participants may utilize that Excess Sick Leave, accrued during the period of employment prior to the effective date of DROP participation, for which the employee was not compensated at the time of entry into the DROP.

d. DROP participants who are employed on December 31st of each year and have not exhausted the six (6) sick leave days provided for in paragraph a. shall receive a pay out of up to three (3) of the unused sick leave days. Payment will be made the following January.

e. There shall be no compensation for any Sick Leave time remaining in the DROP participant's Sick Leave bank upon separation from employment.

f. An employee may utilize available Sick Leave for absences:

i. Due to personal illness or physical incapacity caused by factors that the employee has no reasonable immediate control. Personal illness includes a woman's actual physical inability to work as a result of pregnancy, child birth, or related medical condition.

ii. Necessitated by exposure to contagious disease or condition in which the health of others would be endangered by attendance on duty.

iii. Due to illness of a member of their immediate family who requires their personal care and attention. The term "immediate family" as used in this section shall mean parent, current step parent, current mother-in-law, current father-in-law, current spouse, children, current daughter-in-law, current son-in-law, current step children, brother, sister, grandparent or grandchildren. It shall also include any person who is normally a member of the employee's household.

iv. To report to the Veterans' Administration for medical examinations or other purposes relating to eligibility for disability pension or medical treatment.

g. DROP participants absent for one of the reasons mentioned above shall inform their immediate Supervisor of such absence as soon as possible and failure to do so within the earliest reasonable time, may be the cause of denial of Sick Leave with pay for the period of absence.

h. When an absence occurs as defined in this Article, and the Department Head or designee suspects abuse, a medical certificate may be required.

i. A DROP participant who is seriously ill for more than five (5) days while on Paid Time Off, may, upon application, have the duration of such illness charged against their Sick Leave bank rather than against Paid Time Off. Notice of such illness must be given immediately. Proof of such illness in the form of a physician's certificate shall be submitted by the employee.

ARTICLE 23

SAVINGS CLAUSE

Should any part of this Agreement be rendered or declared illegal or invalid by legislation, decree of a court of competent jurisdiction, Michigan Employment Relations Commission or other established or to be established governmental administrative tribunal, such invalidation shall not effect the remaining portions of this Agreement. Should a provision(s) be declared invalid, the Union and the County may agree on a replacement for the affected provision(s).

ARTICLE 24

SHIFT PREMIUM

Shift premium shall be paid according to the following provisions and terms:

A. Work performed between 8:00 p.m. and 8:00 a.m. shall be paid a premium of fifty ($.50) cents per hour.

ARTICLE 25

SICK LEAVE

A. Participants in the Deferred Retirement Option Plan are not subject to Article 25, Sick Leave, but shall receive Sick Leave in the manner described in Article 22, Deferred Retirement Option Plan.

B. Regular full time employees shall accrue a Sick Leave bank at the rate of up to 12 days per year. Sick Leave shall accumulate only on hours paid.

The paid leave provisions in this contract apply only to full time employees working 37.5 hours or more. All other employees accrue paid leave time in accordance with Michigan's paid leave act and that leave time will be administered according to the acts provisions (PA 338 of 2018 as amended).

C. For Sick Leave usage only, the unused Sick Leave accumulation maximum that an employee can earn will be one hundred eighty days (1350 hours).

For accumulated Sick Leave payoff purposes the maximum Sick Leave accumulation will retain its cap of one hundred twenty-five days (937.5 hours).

D. An employee may utilize available Sick Leave for absences:

1. Due to personal illness or physical incapacity caused by factors that the employee has no reasonable immediate control. Personal illness includes a woman's actual physical inability to work as a result of pregnancy, child birth, or related medical condition.

2. Necessitated by exposure to contagious disease or condition in which the health of others would be endangered by attendance on duty.

3. Due to illness of a member of their immediate family who requires their personal care and attention. The term "immediate family" as used in this section shall mean parent, current step parent, current mother-in-law, current father-in-law, current spouse, children, current daughter-in-law, current son-in-law, current step children, brother, sister, grandparent or grandchildren. It shall also include any person who is normally a member of the employee's household.

4. To report to the Veterans' Administration for medical examinations or other purposes relating to eligibility for disability pension or medical treatment.

E. Any employee absent for one of the reasons mentioned above shall inform their immediate Supervisor of such absence as soon as possible and failure to do so within the earliest reasonable time, may be the cause of denial of Sick Leave with pay for the period of absence.

F. When an absence occurs as defined in this Article, and the Department Head or designee suspects abuse, a medical certificate may be required.

G. An employee who is seriously ill for more than three (3) days while on Paid Time Off, may, upon application, have the duration of such illness charged against their Sick Leave bank rather than against Paid Time Off. Notice of such illness must be given immediately. Proof of such illness in the form of a physician's certificate shall be submitted by the employee.

H. Sick Leave shall be available for use upon accrual.

I. Accumulated Sick Leave Payoff (does not apply to employees hired after 1-1-16)

1. The maximum Accumulated Sick Leave available to be paid off is one hundred twenty-five (125) days (937.5 hours). Any accumulated sick leave above the one hundred twenty-five (125) work days will be considered excess sick leave.

2. Retirement: A regular employee, as defined in Article 5, Employee Defined, who leaves employment because of retirement and is eligible for and receives benefits under Macomb County Employees' Retirement Ordinance, shall be paid for fifty percent (50%) of his/her accumulated and unused Sick Leave at employee's then current rate of pay.

3. In case of death of a regular employee, as defined in Article 5, Employee Defined, payment of their accumulated and unused Sick Leave, at deceased employee's then current rate of pay, shall be made to the deceased employee's estate/trust.

4. Excess sick leave, up to a maximum of 440 hours, will be paid at the time of separation from the County to either those eligible to receive benefits under Macomb County Employees' Retirement Ordinance or to those who have participated in the DROP. The cash payment will be made in the payoff check with normal deductions. This payment will not be included in the Final Average Calculation (FAC).

J. Sick Leave payoff for employees in the Defined Contribution (401(a) Plan):

Upon separation of employment, an employee shall be compensated for a portion of their unused sick leave up to one hundred twenty-five (125) work days. The rate of pay will be based on the employee's hourly rate at the time of separation. The payoff will be based on a percentage in accordance with the following schedule:

Continuous years of Full Time Service	Percentage Payoff Amount
After 5 years	25% of a maximum of 125 work days
After 10 years	50% of a maximum of 125 work days

The cash payment will be made in the final payoff check with all normal payroll deductions.

ARTICLE 26

SPECIAL CONFERENCES

A. Special Conferences mutually agreed upon will be arranged between the Union President and the Director, Human Resources and Labor Relations, or designated representative, for purposes of discussion of important matters. Such meetings shall be between up to three (3) representatives of the Employer and up to three (3) representatives of the Union, unless the Parties mutually agree to include additional persons.

B. Arrangements for such Special Conferences shall be made in advance, in writing, and an agenda of the matters to be taken up at the meeting shall be presented at the time the conference is requested and agreed upon. Matters taken up in Special Conferences shall be confined to those included in the Agenda.

C. The members of the Union shall not lose pay for time spent in such Special Conferences.

ARTICLE 27

STRIKES AND LOCKOUTS PROHIBITED

The Parties hereto recognize that it is essential for the health, safety and public welfare of the County that services to the public be without interruption and that the right to strike is forbidden by the Statutes of the State of Michigan. Any employee guilty of engaging in a slowdown, work stoppage, or strike, shall be subject to disciplinary action up to and including discharge.

The Employer agrees that it shall not lock out its employees.

ARTICLE 28

TEMPORARY ASSIGNMENT

Temporary assignments are made at the discretion of the Employer in order to ensure orderly performance and continuity of services. A regular employee temporarily assigned to a higher job classification for a period in excess of five (5) consecutive working days will receive the minimum rate of the higher classification or one increment added to their current salary, whichever is greater. The employee temporarily assigned must have the current ability to do the available work and meet the minimum qualifications of the higher classification.

The employee temporarily assigned shall be eligible for increments until the maximum salary for the temporary assignment is reached. Payment for such temporary assignment must be authorized in writing by the Department Head and approved by the Director, Human Resources and Labor Relations before the salary adjustment is made.

The procedure set forth in Article 31, Wage and Increment Schedule, shall be utilized to approve or disapprove increments pursuant to this provision.

ARTICLE 29

UNIFORM ALLOWANCE

A. Eligible employees shall receive the annual Uniform Allowance of $400 for the reimbursement of uniforms and equipment purchased in compliance with the Macomb County Health Department Dress Code Policy.

B. In order to be eligible for the annual Uniform Allowance payment employees must have completed a minimum of 6 months of service in the Medical Examiner Investigator classification.

C. Reimbursement is to be made in compliance with the Macomb County Health Department Uniform Reimbursement Policy.

ARTICLE 30

UNION BULLETIN BOARDS

A. The Employer will provide bulletin boards in the respective departments and locations, which may be used by the Union for posting notices of the following topics:

1. Notices of Union Meetings.

2. Notices of Union Elections and results of said Elections

3. Notices of recreational, educational and social events.

B. The bulletin board shall not be used by the Union for disseminating propaganda and among other things, shall not be used by the Union for posting or distributing pamphlets pertaining to political matters.

ARTICLE 31

WAGE AND INCREMENT SCHEDULE

A. Bargaining Unit Wage and Increment Schedules are attached in Appendix A of this Agreement.

B. INCREMENTS: After employment commences, an employee will be eligible to receive one (1) normal wage increment after each thirteen (13) biweekly pay periods of continuous employment until the employee reaches the maximum of his/her wage range. Such increments are found in Appendix A. All increments are to be approved or disapproved by the respective Department Head. If the increment has been disapproved, the employee and the Director, Human Resources and Labor Relations shall be notified in writing by the Department Head of the reason(s) for such disapproval.

ARTICLE 32

WAGE RATES FOR NEW CLASSIFICATIONS

When a new classification is established by the Macomb County Office of the County Executive that is to be placed in the bargaining unit, the Employer shall place the new classification in the Wage Schedule that is found in Appendix A of this Agreement. If the Union does not agree with the Wage Schedule that was assigned by the

Employer, the Union may submit the assignment of the Wage Schedule to the Grievance Procedure at the Third Step.

ARTICLE 33

WORKER'S COMPENSATION

Macomb County will act in accordance with the Workers' Disability Compensation Act of Michigan.

ARTICLE 34

TERMINATION AND MODIFICATION

A. This Agreement shall continue in full force and effect until December 31, 2025.

B. If either party wishes to terminate or modify this Agreement, said party shall provide written notice to the other party to that effect. Said notice shall be made no later than one hundred twenty (120) days prior to the termination date in Paragraph A., above. If neither party gives a notice of termination or modification, or if each party giving notice of termination or modification withdraws said notice prior to the termination date in Paragraph A., above, this Agreement shall continue in full force and effect from year to year thereafter, subject to timely notice of termination or modification by either party in subsequent year(s) of an extended Agreement.

C. Notice of termination or modification shall be made in writing and shall be sent by Certified Mail. If said notice is made to the Union, it shall be sent to POAM, 27056 Joy Road, Redford, MI 48239-1949; if said notice is made to the County, it shall be sent to the Macomb County Director, Human Resources and Labor Relations, 6th Floor, 1 South Main Street, Mount Clemens, Michigan, 48043; address changes shall be made available to the other party, where applicable.

D. It is agreed and understood that the provisions contained herein shall remain in full force and effect so long as they are not in violation of applicable Statutes or Ordinances and remain within the jurisdiction of the County of Macomb.

E. The foregoing Agreement shall not be construed or utilized in any manner that may impede or prevent any elected or appointed Macomb County official from fulfilling or carrying out the Statutory or Constitutional duties of his/her office.

IN WITNESS WHEREOF, the Employer and its Office of the County Executive, by its Director, Human Resources and Labor Relations, and representatives of The Technical, Professional Officeworkers Association of Michigan (TPOAM), on behalf of its represented employees, hereby cause this Agreement and Appendices to be executed.

FOR THE UNION:

Steven Sellers, Business Agent, POAM

FOR THE EMPLOYER:

Karlyn Semlow, Director
Human Resources and Labor Relations

Erick Acre, President, POAM

Dated: May 18, 2023

APPENDIX A

Classification, Wage and Increment Schedule

Medical Examiner Investigator - Full Time	**Pay Grade 8 Full Time**
Medical Examiner Investigator – Part Time	**Pay Grade 8 Part Time**

Pay Grade	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9	Step 10
2023 Professional Technical Administrative (PTA) Pay Grade – Full Time										
F	$48,444.88	$49,849.78	$51,295.43	$52,782.99	$54,313.70	$55,888.80	$57,509.57	$59,177.35	$60,893.49	$62,659.40
2024 Professional Technical Administrative (PTA) Pay Grades – Full Time										
F	$51,351.57	$52,840.77	$54,373.16	$55,949.97	$57,572.52	$59,242.13	$60,960.14	$62,727.99	$64,547.10	$66,418.96
2025 Professional Technical Administrative (PTA) Pay Grades – Full Time										
F	$52,892.12	$54,425.99	$56,004.35	$57,628.47	$59,299.70	$61,019.39	$62,788.94	$64,609.83	$66,483.51	$68,411.53

Pay Grade	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9	Step 10
2023 Professional Technical Administrative (PTA) Pay Grades - Part Time (hourly)										
F	$24.84353	$25.56399	$26.30535	$27.06820	$27.85318	$28.66092	$29.49209	$30.34736	$31.22743	$32.13303
2024 Professional Technical Administrative (PTA) Pay Grades - Part Time (hourly)										
F	$25.58884	$26.33091	$27.09451	$27.88025	$28.68878	$29.52075	$30.37685	$31.25778	$32.16425	$33.09702
2025 Professional Technical Administrative (PTA) Pay Grades - Part Time (hourly)										
F	$26.35651	$27.12084	$27.90735	$28.71666	$29.54944	$30.40637	$31.28816	$32.19551	$33.12918	$34.08993

Appendix B

Active Employee Benefits

Blue Care Network

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCN does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCN administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCN disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCN, or whether the coverage provides minimum essential coverage.

CLSSLG

Macomb Co Employees - Hard Cap-Active/COBRA

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Plan Types **Plan Type:** TPA

BCN HMO Active Employees

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call 800-662-6667 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 800-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$6,350/$12,700	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan does not cover	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the phone number on the back of your ID card for a list of network providers. 800-662-6667 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	$20 copay for online visits.
	Specialist visit	$30 copay/visit	Not covered	Requires referral. No charge for allergy injections, allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	May require preauthorization / No charge for lab services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Requires preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/customdruglist	Tier 1 - Mostly Generics	$10 copay/30 days	Not covered	Preauthorization & step-therapy apply to select drugs. 50% coinsurance for sexual dysfunction drugs. Effective 1/1/2013 Tier 1 contraceptives are covered in full 90 day mail order and retail copays are 2x the standard retail copays.
	Tier 2 - Preferred Brand	$25 copay/30 days	Not covered	
	Tier 3 - Non-Preferred Brand	$50 copay/30 days	Not covered	
	Specialty drugs	Tiered copays listed above apply	Not covered	Limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	May require preauthorization/50% coinsurance for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fees	No charge	Not covered	See "Outpatient surgery facility fee"

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay waived if admitted
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when preauthorized
	Urgent care	$30 copay/visit	$30 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required. 50% coinsurance for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fee	No charge	Not covered	See "Hospital Stay surgery facility fee"
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No Charge	Not covered	Preauthorization is required
	Inpatient services	No Charge	Not covered	Preauthorization is required
If you are pregnant	Office visits	No charge	Not covered	Postnatal and non-routine prenatal office visits-$20 copay
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	$30 copay/visit	Not covered	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	$30 copay/visit	Not covered	Requires preauthorization/ One period of treatment for any combination of therapies within 60 consecutive days per medical episode. Subject to meaningful improvement within 60 days.
	Habilitation services	ABA - $20 copay per visit. $30 copay per visit for PT/OT/ST	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires preauthorization.
	Skilled nursing care	No charge	Not covered	Requires preauthorization/Limited to 730 days
	Durable medical equipment	No charge	Not covered	Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	Not covered	Inpatient care requires preauthorization. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's glasses	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's dental check-up	Not covered	Not covered	Contact benefit administrator for coverage.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture (if prescribed for rehabilitation purposes) • Cosmetic surgery • Dental Care (Adult) • Elective Abortion	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery • Chiropractic care	• Infertility treatment • Hearing Aid

Macomb County Blue Care Network Plans generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Care Network Plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Macomb County at (586) 469-5280.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Care Network or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Macomb County HRLR Department at (586) 469-5280.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform., or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact : Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284,Southfield, MI 48086 or fax. 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs; call 1-877-999-6442 or fax: 517-284-8838.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this Plan Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Plan Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example, prescription drugs, through another carrier.)

Translation available

To get help reading in your language call the customer service number on the back of your ID card

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$0
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$130**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$0
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$860**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$0
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

اگر آپ، یا آپ جن کی مدد کر رہے ہیں، کو مدد کی ضرورت ہے تو آپ کو اپنی زبان میں بلا لاگت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے اپنے کارڈ کے پیچھے دیے گئے کسٹمر سروس نمبر پر کال کریں، یا اگر آپ پہلے سے ممبر نہیں ہیں تو 877-469-2583 TTY:711 پر کال کریں۔

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号（メンバーでない方は 877-469-2583, TTY: 711）までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Blue Cross Blue Shield

Community Blue PPO ASC

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$1,500 Individual/ $3,000 Family	$3,000 Individual/ $6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$6,350 Individual/ $12,700 Family	$12,700 Individual/ $25,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$40 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	$7 copay/prescription for retail 30-day supply; $14 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand-name drugs	$35 copay/prescription for retail 30-day supply; $70 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Nonpreferred brand-name drugs	$70 copay/prescription for retail 30-day supply; $140 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible does not apply	$250 copay/visit; deductible does not apply	Copay waived if admitted or for an accidental injury.

	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$40 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% coinsurance	20% coinsurance for mental health; 40% coinsurance for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Physician certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	Not covered for Applied Behavior Analysis; Not covered for Physical, Speech and Occupational Therapy	Not covered for Applied Behavior Analysis; Not covered for Physical, Speech and Occupational Therapy	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Physician certification required. Visit limits apply.
If your child needs dental or	Children's eye exam	Not covered	Not covered	None

eye care For more information on pediatric vision or dental, contact your plan administrator	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture treatment	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long term care	• Weight loss programs
• Dental care (Adult)	• Routine eye care (Adult)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Coverage provided outside the United States. See http://provider.bcbs.com	• Non-emergency care when traveling outside the U.S
• Chiropractic care	• Hearing aids	• Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$1,500
■ Specialist copayment	$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,270**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$1,500
■ Specialist copayment	$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$1,500
■ Specialist copayment	$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$90
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,660**

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

Questions: Call or visit us at www.bcbsm.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. to request a copy.

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إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر ئێوە یان کەسێک کە ئێوە یارمەتی دەدەن، پێویستی بە یارمەتی هەیە، مافی ئەوەتان هەیە بە خۆڕایی یارمەتی و زانیاری بە زمانەکەی خۆتان وەربگرن. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری کڕیار لەسەر پشتەوەی کارتەکەتان یان 877-469-2583 TTY:711 بکە ئەگەر ئێستا ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号（メンバーでない方は 877-469-2583, TTY: 711）までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Blue Cross Blue Shield

Simply Blue PPO HSA ASC with Rx

(High Deductible Health Plan)

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

MACOMB COUNTY EMPLOYEES

Simply Blue PPO HSA℠ ASC with Rx

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Note to ASC groups: Before completing this template, please reference the disclaimer on the attached cover page.

Coverage for: Individual/Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$2,000 Individual/ $4,000 Family	$4,000 Individual/ $8,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$3,000 Individual/ $6,000 Family	$6,000 Individual/ $12,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care or Online visit to treat an injury or illness	No Charge	20% coinsurance	None
	Specialist visit	No Charge	20% coinsurance	None
	Preventive care/ screening/ immunization	No Charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	$10 copay/prescription for retail 30-day supply; $20 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 20% coinsurance of the approved amount	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network.
	Preferred brand-name drugs	$40 copay/prescription for retail 30-day supply; $80 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 20% of the approved amount	
	Non preferred brand-name drugs	$80 copay/prescription for retail 30-day supply; $160 copay/prescription for retail or mail order 90-day supply	In-Network copay plus an additional 20% of the approved amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	None
	Physician/surgeon fees	No Charge	20% coinsurance	None
	Emergency room care	No Charge	No Charge	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency medical transportation	No Charge	No Charge	Mileage limits apply
	Urgent care	No Charge	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Preauthorization is required
	Physician/surgeon fee	No Charge	20% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No Charge	No Charge	None
	Inpatient services	No Charge	20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge	Prenatal: 20% coinsurance Postnatal: 20% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	No Charge	20% coinsurance	None
	Childbirth/delivery facility services	No Charge	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Preauthorization is required.
	Rehabilitation services	No Charge	20% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No Charge	No Charge	Preauthorization is required. Limited to 90 days per member per calendar year
	Durable medical equipment	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge	No Charge	Preauthorization is required. Visit limits apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
For more information on pediatric vision or dental, contact your plan administrator	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture treatment
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com
- Hearing aids
- If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses - like the deductible, co-payments, or co-insurance, or benefits not otherwise covered
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$2,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,090**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$2,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$2,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

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Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号（メンバーでない方は 877-469-2583, TTY: 711）までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Health Alliance Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2021 - 12/31/2021**

Alliance Health and Life Insurance Company **AS000098 / XR002358 / XW000713**

Coverage for: Individual + Family | Plan Type: ASO HMO

AS000098 XR002358 XW000713

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-422-4641 or visit http://www.hap.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-422-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductibles before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Out-of-Pocket Limit:** **$6,600** individual/ **$13,200** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover. All other cost share accumulates unless otherwise specified in Plan Documents.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hap.org or call 1-800-422-4641 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plans network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org.

	All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay	Not Covered	
	Specialist visit	$40 Copay	Not Covered	
	Other practitioner office visit	Telehealth Visit: $25 Copay Chiropractic Visit: Not Covered	Not Covered	Telehealth: Through our contracted telehealth services provider.
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org. You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require preauthorization
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Services require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.hap.org	Preferred Generic drugs	$20 Copay / prescription (retail)	Not Covered	Costs shown apply to a 30-day supply of drugs. A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Applies to all Generic and Brand type drugs.
	Non-preferred Generic drugs	$20 Copay / prescription (retail)	Not Covered	
	Preferred Brand drugs	$40 Copay / prescription (retail)	Not Covered	
	Non-preferred Brand drugs	$60 Copay / prescription (retail)	Not Covered	
	Preferred Specialty drugs	$60 Copay / prescription (retail)	Not Covered	All specialty drugs are limited to a 30-day supply at a specialty pharmacy only. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a Copay or max is shown, You will pay 2 times that amount for a supply up to 60 days, and 3 times that amount for a supply of up to 90 days. Other exclusions & limitations may apply.
	Non-preferred Specialty drugs	$60 Copay / prescription (retail)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	No Charge	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	Emergency room care	$200 Copay	$200 Copay	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency transport only
	Urgent care	$50 Copay	$50 Copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755.
	Inpatient services	No Charge	Not Covered	Services require preauthorization. Services can be accessed by calling 1-800-444-5755.
If you are pregnant	Office visits	$40 Copay	Not Covered	Prenatal covered under Preventive Services.
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility services	No Charge	Not Covered	Some services require preauthorization
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Does not include Rehabilitation Services; Unlimited.
	Rehabilitation services	No Charge	Not Covered	May be rendered at home; Up to 60 combined visits per benefit period.
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services; Up to 730 days. Maximum benefit renews after 60 days of nonconfinement.
	Durable medical equipment	No Charge	Not Covered	Covered for approved equipment only
	Hospice services	No Charge	Not Covered	Up to 210 days per lifetime.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$40 Copay	Not Covered	One exam per benefit period. For non-routine visits see Specialist Office Visit.
	Children's glasses	No Charge	Not Covered	Glasses or contacts for adults and children are covered once during each 12-month consecutive period. Detailed information regarding coverage of lenses and Collection frames can be found in your policy or plan documents.
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Chiropractic Care	• Cosmetic Surgery
• Dental Care (Adult)	• Long-Term Care	• Non-Emergency Care Outside the U.S.
• Private Duty Nursing	• Routine Foot Care	• Voluntary Termination of Pregnancy

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Hearing Aids	• Infertility Treatment
• Routine Eye Care (Adult)	• Weight Loss Programs	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: contact the plan at 1-800-422-4641 you may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov.Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the plan at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P.O.Box 30220, Lansing, MI 48909-7720, http://michigan.gov/difs; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: http://michigan.gov/difs or e-mail difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Please see a full list of Language Access Services following the Coverage Examples at the end of the Summary of Benefits of Coverage.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$0	■ The plan's overall deductible	$0	■ The plan's overall deductible	$0
■ Specialist copayment	$40	■ Specialist copayment	$40	■ Specialist copayment	$40
■ Hospital (facility)	$0	■ Hospital (facility)	$0	■ Hospital (facility)	$0
■ Other coinsurance	0%	■ Other coinsurance	0%	■ Other coinsurance	0%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (*prenatal care*)		Primary care physician office visits (*including disease education*)		Emergency room care (*including medical supplies*)	
Childbirth/Delivery Professional Services		Diagnostic tests (*blood work*)		Diagnostic tests (*x-ray*)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (*crutches*)	
Diagnostic tests (*ultrasounds and blood work*)		Durable medical equipment (*glucose meter*)		Rehabilitation services (*physical therapy*)	
Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$10	Copayments	$944	Copayments	$325
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$61	Limits or exclusions	$22	Limits or exclusions	$0
The total Peg would pay is	**$71**	**The total Joe would pay is**	**$966**	**The total Mia would pay is**	**$325**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance

We want you to easily get the information you need. To request assistance in a language other than English, call (800) 422-4641 (TTY: 711).

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم 4641-422 (800) أو خدمة الهاتف النصي: 711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। (800) 422-4641 বা TTY: 711 নম্বরে কল করুন।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 422-4641 或 TTY 用户請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero (800) 422-4641 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 422-4641 まで、お電話にてご連絡ください。
TTY ユーザーは 711 までご連絡ください。

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해 주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641, los usuarios TTY deben llamar al 711.

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܩܒܠܬ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 422-(800)
4641 ܐܘ ܥܠ TTY: 711.

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad.
Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.

Appendix C

Post November 1, 2013

Retirees

Blue Care Network

(Post November 1, 2013 Retirees)

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

CLSSLG

Macomb Co Employees - Hard Cap-Retired

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2020

Coverage for: All Plan Types

Plan Type: TPA

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call 800-662-6667 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 800-662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$6,350/$12,700	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan does not cover	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the phone number on the back of your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care or Online visit to treat an injury or illness	$20 copay/visit	Not covered	$20 copay for online visits.
	Specialist visit	$30 copay/visit	Not covered	Requires referral. No charge for allergy injections, allergy office visit and testing /30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	May require preauthorization / No charge for lab services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Requires preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/customdruglist	Tier 1 - Mostly Generics	$10 copay/30 days	Not covered	Preauthorization & step-therapy apply to select drugs. 50% coinsurance for sexual dysfunction drugs. Effective 1/1/2013 Tier 1 contraceptives are covered in full 90 day mail order and retail copays are 2x the standard retail copays.
	Tier 2 - Preferred Brand	$25 copay/30 days	Not covered	
	Tier 3 - Non-Preferred Brand	$50 copay/30 days	Not covered	
	Specialty drugs	Tiered copays listed above apply	Not covered	Limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	May require preauthorization/50% coinsurance for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fees	No charge	Not covered	See "Outpatient surgery facility fee"

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay waived if admitted
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when preauthorized
	Urgent care	$30 copay/visit	$30 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required. 50% coinsurance for TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fee	No charge	Not covered	See "Hospital Stay facility fee"
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No Charge	Not covered	Preauthorization is required
	Inpatient services	No Charge	Not covered	Preauthorization is required
If you are pregnant	Office visits	No charge	Not covered	Postnatal and non-routine prenatal office visits-$20 copay
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	$30 copay/visit	Not covered	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	$30 copay/visit	Not covered	Requires preauthorization/ One period of treatment for any combination of therapies within 60 consecutive days per medical episode. Subject to meaningful improvement within 60 days.
	Habilitation services	ABA - $20 copay per visit. $30 copay per visit for PT/OT/ST	Not covered	PT/OT/ST for autism spectrum disorder has unlimited visits. Requires preauthorization.
	Skilled nursing care	No charge	Not covered	Requires preauthorization/Limited to 730 days

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No charge	Not covered	Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full
	Hospice services	No charge	Not covered	Inpatient care requires preauthorization. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's glasses	Not covered	Not covered	Contact benefit administrator for coverage.
	Children's dental check-up	Not covered	Not covered	Contact benefit administrator for coverage.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture (if prescribed for rehabilitation purposes) • Cosmetic surgery • Dental Care (Adult) • Elective Abortion	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult)	• Routine foot care • Weight loss programs • Hearing Aids

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery • Chiropractic care	• Infertility treatment

Macomb County Blue Care Network Plans generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Care Network designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Macomb County at (586) 469-5280.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Care Network Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Macomb County HRLR Department at (586) 469-5280.

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform., or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact : Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284,Southfield, MI 48086 or fax. 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs; call 1-877-999-6442 or fax: 517-284-8838.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this Plan Provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Plan Meet the Minimum Value Standard? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example, prescription drugs, through another carrier.)

Translation available
To get help reading in your language call the customer service number on the back of your ID card

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$0
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$130**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$0
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$860**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$0
■ Specialist copayment	$30
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ، یان کەسێک کە یارمەتی دەدەیت، پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچوونێک یارمەتی و زانیاری بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری کڕیار لەسەر پشتەوەی کارتەکەت بکە، یان 877-469-2583 TTY:711 بۆ ئەو کەسانەی کە ئەندام نین.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号（メンバーでない方は 877-469-2583, TTY: 711）までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Blue Cross Blue Shield

Community Blue PPO ASC

(Post November 1, 2013 Retirees)

As a self-funded group, you are solely responsible for compliance with the federal Summary of Benefit and Coverage (SBC) rules, including SBC creation and distribution. BCBSM does not assume any responsibility for SBC rule compliance relating to your group health plan, or for creation or disclosure of compliant SBCs. This SBC template document is being provided as an example that may contain useful information concerning your BCBSM administered coverage as you create your own group health plan's SBC. This SBC template document being provided is not fully compliant with the SBC federal rules. It is your responsibility to work with your legal counsel to ensure proper compliance with the federal SBC rules. This SBC template document does not constitute legal, tax, actuarial, accounting, benefit design, compliance or other advice. BCBSM disclaims any liability or responsibility for any non-compliance by your group health plan with SBC rules and regulations relating to creation, disclosure or other requirements. You should also note that there may be additional special circumstances which may be applicable to your specific group health plan situation which may affect SBC content, including but not limited to account type arrangements such as flexible spending accounts (FSA), health reimbursement arrangements (HRA), and health savings accounts, (HSA), or for example, wellness programs, reference based pricing or benefits, or coverage not administered by BCBSM, or whether the coverage provides minimum essential coverage. If you have an ASC Plan Modification, it may be defined here in only a limited way.

MACOMB COUNTY EMPLOYEES

Community Blue PPO℠ ASC

Note to ASC groups: Before completing this template, please reference the disclaimer on the attached cover page.

Coverage for: Individual/Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call the number on the back of your BCBSM ID card to request a copy.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$1,500 Individual/ $3,000 Family	$3,000 Individual/ $6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$6,350 Individual/ $12,700 Family	$12,700 Individual/ $25,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$40 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	$7 copay/prescription for retail 30-day supply; $14 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand-name drugs	$35 copay/prescription for retail 30-day supply; $70 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Nonpreferred brand-name drugs	$70 copay/prescription for retail 30-day supply; $140 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible does not apply	$250 copay/visit; deductible does not apply	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$40 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% coinsurance	20% coinsurance for mental health; 40% coinsurance for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Physician certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	Not covered for Applied Behavior Analysis; Not covered for Physical, Speech and Occupational Therapy	Not covered for Applied Behavior Analysis; Not covered for Physical, Speech and Occupational Therapy	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Physician certification required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture treatment
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com
- Non-emergency care when traveling outside the U.S
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$1,500
■ Specialist copayment	$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,270**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$1,500
■ Specialist copayment	$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$1,500
■ Specialist copayment	$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$90
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,660**

If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, copayments, or coinsurance, or benefits not otherwise covered.

The plan would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

اگر آپ، یا آپ جن شخص کی مدد کر رہے ہیں، کو مدد کی ضرورت ہے تو آپ کو بلا لاگت اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے اپنے کارڈ کے پیچھے دیے گئے کسٹمر سروس نمبر پر کال کریں، یا اگر آپ پہلے سے ممبر نہیں ہیں تو 877-469-2583 TTY:711 پر کال کریں۔

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号（メンバーでない方は 877-469-2583, TTY: 711）までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Health Alliance Plan

(Post November 1, 2013 Retirees)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: As of 01/01/2020

Administered by Alliance Health and Life Insurance Company

Coverage for: Individual+Family | **Plan Type:** ASO HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-766-4709 or visit www.hap.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-866-766-4709 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
What is the out-of-pocket limit for this plan?	**$6,600** person / **$13,200** family	The out of pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out of pocket limit until the overall family out of pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Balance billing Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out of pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.hap.org or call 1-866-766-4709** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out of network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out of network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not Covered	Visits are face-to-face, telephonic, or through secure electronic portal
	Specialist visit	$30 copay per visit	Not Covered	————None————
	Other practitioner office visit	$20 PCP Other Practitioner copay per visit/ $30 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic Care and Acupuncture Not Covered
	Preventive care/ screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org. You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require preauthorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Services require preauthorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org	Generic drugs	Preferred $15 copay/prescription (retail) Non-Preferred $15 copay/prescription (retail)	Not Covered	Retail: 30 day supply for non-maintenance drugs at 1 copay; 90 day supply for eligible maintenance drugs at 2 copays; Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 copays.
	Preferred brand drugs	$30 copay/prescription (retail)	Not Covered	
	Non-preferred brand drugs	$50 copay/prescription (retail)	Not Covered	
	Specialty drugs	Preferred $50 copay/prescription (retail) Non-Preferred $50 copay/prescription (retail)	Not Covered	Specialty drugs not available at 90 day or mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	————None————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copay per visit	$150 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency medical transportation Only
	Urgent care	$30 copay per visit	$30 copay per visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay per visit	Not Covered	* Services can be accessed by calling 1-800-444-5755
	Inpatient services	No Charge	Not Covered	** Services can be accessed by calling 1-800-444-5755
If you are pregnant	Office visits	$30 copay per visit	Not Covered	No Charge for Prenatal care
	Childbirth/delivery professional services	No Charge	Not Covered	----------None----------
	Childbirth/delivery facility services	No Charge	Not Covered	**Some services require preauthorization.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	----------None----------
	Rehabilitation services	No Charge	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require preauthorization. *See outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services- Up to 730 days, renewable after 60 days
	Durable medical equipment	No Charge	Not Covered	Coverage provided for approved equipment based on HAP's guidelines. Some services require preauthorization.
	Hospice services	No Charge	Not Covered	Up to 210 days per lifetime

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$30 copay per visit	Not Covered	No Charge for one routine eye exam
	Children's glasses	Not Covered	Not Covered	——None——
	Children's dental check-up	Not Covered	Not Covered	——None——

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care (Only when meets plan guidelines)
- Vision Hardware (Unless additional rider purchased)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Infertility Treatment (Only when meets plan guidelines)
- Routine Eye Care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue coverage after it ends. For more information on you rights to continue coverage, contact the plan at 1-866-766-4709; you may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.Healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the plan at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P.O. Box 30220, Lansing, MI 48909-7720, http://michigan.gov/difs; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: http://michigan.gov/difs or e-mail difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum essential coverage for a month, you'll have to pay when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum value standards, you may be eligible for premium tax credits to help you pay for a plan through the Marketplace.

Language Access Services:
Please see a full list of Language Access Services following the Coverage Examples at the end of the Summary of Benefits of Coverage.
To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Macomb County Health Alliance Plans generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Health Alliance Plan may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Macomb County at (586) 469-5280.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Health Alliance Plan Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Macomb County HRLR Department at (586) 469-5280.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	$30
Hospital (facility) copayment	**$0**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$610
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$670**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	$30
Hospital (facility) copayment	**$0**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,075
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,130**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	$30
Hospital (facility) copayment	**$0**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$90**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم 422-4641 (800) أو خدمة الهاتف النصي: 711.

নজর দিন: আপনি বাংলা ভাষায় কথা বলে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ।
(800) 422-4641 বা
TTY: 711 নম্বরে কল করুন।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 422-4641 或 TTY 用户請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 422-4641 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 422-4641 まで、お電話にてご連絡ください。TTY ユーザーは 711 までご連絡ください。

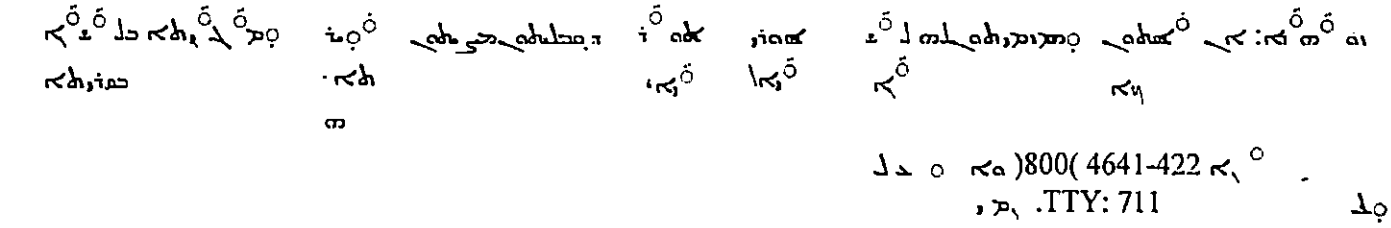
주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641, los usuarios TTY deben llamar al 711.



PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.

Appendix D

Active Employees Dental Benefits

Delta Dental

Delta Dental of Michigan

Dental Benefit Highlights for

Macomb County Active and Retiree Dental Plan

DELTA DENTAL®

Delta Dental PPO (Point-of-Service)	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	75%	75%
Endodontic Services - root canals	80%	75%	75%
Periodontic Services - to treat gum disease	80%	75%	75%
Oral Surgery Services - extractions and dental surgery	80%	75%	75%
Major Restorative Services - crowns	80%	75%	75%
Other Basic Services - misc. services	80%	75%	75%
Relines and Repairs - to bridges, implants, and dentures	80%	75%	75%
Major Services			
Prosthodontic Services - bridges, implants, and dentures	50%	50%	50%

** When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.*

Maximum Payment – $1,000 per person total per Benefit Year on all services.

Deductible – None.

Note - *This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.*

Welcome to Michigan's largest dental benefits family!

As a member of Delta Dental of Michigan, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier.

- It's easy to find a dentist! Four out of five dentists nationwide participate in our network.
- You have superior access to care and fee savings because of our agreements with participating dentists.
- Our dentists cannot balance bill you, which means more money in your pocket!
- No troublesome paperwork! Network dentists will fill out and file your claims.
- Pay only your copayments and/or deductibles when you receive care from network dentists – there are no hidden fees.
- You can still visit nonparticipating dentists, but you may be billed the full amount at the time of service and then have to wait to be reimbursed.

Quality Dental Program

With our quick and accurate claims processing, *we pay more than 90% of claims in 10 days or less.* Delta Dental also offers world-class customer service from our Certified Center of Excellence call center, as awarded by Benchmark Portal.

Online Access

Our online Consumer Toolkit lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more – all at your own convenience.

A Healthy Smile

Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions?

If you have questions, please call our Customer Service team at 800-524-0149 (TTY users call 711) or look online at www.DeltaDentalMI.com.

Golden Dental

Certificate of Coverage

Macomb County

OFFICE VISIT CO-PAY	**$5.00**
CLASS I **Diagnostic and Preventive:** Exams, Radiographs, Prophylaxis, Fluoride Treatment (up to age 19), Sealants (1st and 2nd Molars only – once in lifetime up to age 18), Space Maintainers (Primary Teeth only up to age 19)	**100%**
CLASS II **Restorative:** Fillings, Root Canals and Routine Extractions performed by General Provider	**90%**
CLASS III **Prosthetic:** Crowns, Bridges, Partial and Complete Dentures	**75%**
CLASS IV **Specialty Care:** Oral Surgery (including General Anesthesia) Endodontics Periodontics Pedodontics	**75%**
ORTHODONTICS: Dependents up to age 19 (Lifetime Maximum) Member & Spouse (Lifetime Maximum)	**$2,200** **$1,800**
Annual Maximum (per member per year):	**Unlimited**
Annual Renewal:	**01/01**
Membership Card Reads:	**MACOMB**

Dependents are covered up to the age of 26 for CLASS I – IV only.

29377 Hoover Road – Warren, MI 48093
Phone: 1-800-451-5918 * Fax: 586-573-8720
website: www.goldendentalplans.com

GOLDEN DENTAL PLANS, INC.
EXCLUSIONS, LIMITATIONS, AND EXCEPTIONS

I. General Exclusions, Limitations, and Exceptions

NOTE: No benefits will be paid under this Policy for the following treatments, services and care, unless otherwise indicated.

1	Dental services not appearing on the Schedule of Benefits.
2	Dental treatment for cosmetic purposes, unless specifically indicated on a specific plan.
3	Dental treatment performed in a hospital and/or any related hospital-fee.
4	Treatment of cleft palate, anodontia and mandibular prognathism.
5	Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained.
6	The cost of services secured from physicians, Dentists or Dental Surgeons, other than authorized GDP Providers, will not be paid for unless expressly authorized in writing by the Primary Care Dentist as cited under Emergency Coverage and Out-of-Area Emergency Coverage provisions.
7	Treatment for any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement under any Workmen's Compensation or Occupational Disease Law, even though You or Your Covered Dependent fails to claim the right of such benefits, provided that this exclusion will only apply to the extent that such benefits are payable through other plans.
8	Treatment for any disease, condition or injuries sustained, as a result of war, declared or undeclared, or any illness or injury occurring after the effective date of the Policy and caused by atomic explosion or exposure, whether or not the result of war.
9	Care of treatment obtained from or for which payment is made by any Federal, State, or County Municipal, or other governmental agency, including any foreign government.
10	Dental implants or transplants.
11	No Covered Person will be denied dental coverage due to trauma. However, dental care coverage under this Policy may not cover the Covered Person for certain traumatic events that may occur if those procedures are specifically excluded in this Policy. A Covered Person who requires dental care due to a serious trauma will not be covered for dental care in those areas that are specifically described as excluded.
12	A nominal administrative fee (i.e., sterilization, office visit, etc.) charged by selected dental offices.
13	Services or appliances started before a Covered Person became eligible under this Policy (i.e., teeth prepared for crowns or root canals in progress).
14	Prescription drugs.
15	Nitrous oxide analgesia.
16	Preventative control programs, including home care items.
17	Services started after termination of coverage.
18	Charges for failure to keep a scheduled visits with the Dentist.
19	Lost, missing, or stolen appliances (i.e., retainers, Occlusal guards, partial or complete dentures, or flippers).

GOLDEN DENTAL PLANS, INC.
EXCLUSIONS, LIMITATIONS, AND EXCEPTIONS

I. General Exclusions, Limitations, and Exceptions, *continued*

20	Duplicate full or partial dentures.
21	Inlays, unless listed as a Covered Service in the Schedule of Benefits.
22	Porcelain, porcelain substrate, and cast restorations on primary (baby) teeth.
23	Cysts and malignancies.
24	Removal of impacted teeth that exhibit no symptoms or pathology.
25	Consultations or examinations/evaluations for non-covered services.
26	Services or appliances performed by a Dentist whose practice is limited to prosthodontics
27	Behavior management fees for covered persons requiring additional or unusual efforts to complete a dental procedure.
28	Soft tissue management (i.e., irrigation, infusion, or special toothbrush).
29	Restorative work caused by orthodontic treatment.
30	Composite resin restorations on occlusal surfaces of bicuspids and molars.
31	Biopsy or Brush Biopsy to detect cancer.
32	Claims submitted due to auto accident, which should be submitted to automobile insurance carrier.
33	Claims reported as accident on school grounds, which should be submitted to school's primary insurance.
34	General anesthesia and the services of a special anesthesiologist unless authorized by employer group.
35	Treatment of fractures and dislocations.
36	Any service that is not specifically listed.
37	Congenital malformation.
38	Dispensing of drugs not normally supplied in a dental office.
39	Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
40	Prophylactic removal of impactions (asymptomatic nonpathological).
41	Specialist consultations for noncovered benefits.
42	Dental expenses incurred with any dental procedure started prior to the enrollee's eligibility.
43	Services rendered by a dentist beyond the scope of his/her license.
44	Services rendered by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
45	Charges for duplication of radiographs.
46	Charges for temporary appliances.
47	Charges for experimental or investigational services or supplies.

48	Services that the dentist feels, in his or her professional judgement, should not be provided.
49	Instructions in dental hygiene, dietary planning or plaque control.
50	Missed appointments or completion of claim forms. Infection control, including sterilization of supplies and equipment.

II. Orthodontic Exclusions, Limitations, and Exceptions

1	Retreatment of prior Orthodontic problems, unless provided under this policy or any extension or renewal of this Policy
2	Patients with severe disabilities that may prevent satisfactory Orthodontic results
3	Any charge made by the Orthodontist for the cost of replacement and/or repair of an appliance furnished to the patient, which is lost or broken through no fault of the Orthodontist
4	Interceptive Orthodontic Treatment is not a covered benefit
5	Surgical procedures incidental to orthodontic treatment
6	Myofunctional therapy
7	Supplemental appliances not routinely used in typical orthodontic cases (i.e., Invisalign)
8	Active treatment extending more than 24 months form the point of banding due to lack of patient cooperation. For cased extending past 24 months, the Covered Person will be charged a monthly fee that is prorated at the Orthodontist's Submitted Fees.
9	Treatment started before the Covered Person became eligible under this policy
10	Transfer to another Dentist after banding has been initiated
11	Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and are subject to additional charges.
12	Orthodontic Benefit is once in a lifetime benefit per member.

Appendix E

Active Employees Vision Benefits

BCBSM Vision Benefits

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MACOMB COUNTY EMPLOYEES
0070004480075 - 08BG2
Effective Date: 01/01/2023

Vision Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance ***plus*** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None (member responsible for difference between approved amount and provider's charge)
Medically necessary contact lenses	None	None (member responsible for difference between approved amount and provider's charge)
Contact lens suitability examination (fitting and evaluation) **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	Up to $60 copay	

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $58 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. • Standard Progressive Lenses - Covered when rendered by a VSP network doctor	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	

ADM PLANYR JAN;ASCMOD 9778 VIS;BLUE VISION;BV SPL;BV-CLSE;BVC;BVFL;BVPP CHOICE NET

Benefits	VSP network doctor	Non-VSP provider
Standard frames	$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less	Reimbursement up to $65 less $10 copay (member responsible for any difference)
Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	One frame in any period of 12 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	
Contact lens suitability examination (fitting and evaluation) Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$120 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	

HAP

Please refer to the HAP Medical Benefits Summary

MEMORANDUM OF UNDERSTANDING

REGARDING CERTAIN HEALTH BENEFITS

WHEREAS, The County of Macomb currently offers health insurance coverage to covered females that includes an elective abortion benefit and excludes prescription drug coverage for contraceptives and excludes coverage for voluntary sterilization; and,

WHEREAS, The Macomb County Board of Commissioners has, by resolution, forbidden the use of public funds for elective abortion;

NOW BE IT RESOLVED THAT, the County of Macomb and the POAM hereby agree to remove elective abortion coverage from the health insurance offered through their Collective Bargaining Agreement and substitute prescription drug coverage for contraceptives and coverage for voluntary sterilization. Provided, however, nothing in this Memorandum of Understanding shall deny medically necessary care to a covered female, or apply in cases where pregnancy is the result of criminal sexual assault.

FOR THE UNION:

Steven Sellers, Business Agent, POAM

FOR THE EMPLOYER:

Karlyn Semlow, Director
Human Resources and Labor Relations

Erick Acre, President, POAM

Dated: May 18, 2023